(18)

No. 95-1594-CFX Title: Barbara A. De Buono, New York Commissioner of Health, et al., Petitioners
v.
NYSA-ILA Medical and Clinical Services Fund, etc., et al.

Docketed:
April 4, 1996

Court: United States Court of Appeals for the Second Circuit

Entry	Date	Proceedings and Orders
	Apr 3 1996	Petition for writ of certiorari filed. (Response due May 4, 1996)
	May 2 1996	Brief amici curiae of Healthcare Association of New York State, et al. filed.
	May 2 1996	Brief of respondents NYSA-ILA Medical and Clinical Services, et al. in opposition filed.
	May 2 1996	Brief amici curiae of Connecticut, et al. filed.
	May 10 1996	Reply brief of petitioners filed.
	May 15 1996	DISTRIBUTED. May 31, 1996
	Jun 3 1996	The Solicitor General is invited to file a brief in this case expressing the views of the United States.
	Sep 20 1996	Brief amicus curiae of United States filed.
	Sep 25 1996	REDISTRIBUTED. October 11, 1996
	Oct 7 1996	REDISTRIBUTED. October 11, 1996
	Oct 15 1996	Petition GRANTED. SET FOR ARGUMENT February 24, 1997. **********
	Nov 27 1996	Brief amicus curiae of National Employment Lawyers Association filed.
	Nov 27 1996	Brief amici curiae of National Governors' Association, et al. filed.
	Nov 27 1996	Brief amici curiae of Connecticut, et al. filed.
	Nov 29 1996	Brief amicus curiae of American Federation of State County and Municipal Employees filed.
	Nov 29 1996	Brief amici curiae of Healthcare Association of New York State, et al. filed.
	Nov 29 1996	Brief amicus curiae of United States filed.
	Nov 29 1996	Joint appendix filed.
	Nov 29 1996	Brief of petitioners Barbara De Buono, et al. filed.
	Dec 30 1996	Brief of respondents NYSA-ILA Medical and Clinical Services Fund and its Trustees filed.
	Dec 30 1996	Brief amicus curiae of Self-Insurance Institute of America, Inc. filed.
	Jan 6 1997	Motion of the Acting Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Jan 8 1997	CIRCULATED.
	Jan 21 1997	Motion of the Acting Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Jan 28 1997	Reply brief of petitioners Barbara De Buono, et al. filed.
	Feb 14 1997	Record filed.
	Feb 24 1997	ARGUED.

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(1) 95-1594

No. ———

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commisisoner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

against

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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PETITION FOR A WRIT OF CERTIORARI

DENNIS C. VACCO
Attorney General of the
State of New York
120 Broadway
New York, N.Y. 10271
(212) 416-8707
Attorney for Petitioners

VICTORIA A. GRAFFEO
Solicitor General

PETER H. SCHIFF
Deputy Solicitor General

DANIEL F. DE VITA
Assistant Attorney General
In Charge of Labor Bureau

M. PATRICIA SMITH *
Assistant Attorney General

* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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QUESTION PRESENTED

Whether the Second Circuit's decision that section 514(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a) preempts N.Y. Pub. Health Law § 2807-d, which imposes a tax of six-tenths of one percent on the gross receipts from patient care services and other operating income of all hospials in New York State, insofar as it is applied to the income of medical centers owned and operated by an ERISA funds, is in conflict with, *inter alia, New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,* 115 S. Ct. 1671 (1995)?

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

No. ———

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commisisoner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

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NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

PETITION FOR A WRIT OF CERTIORARI

Petitioners Barbara A. De Buono, M.D.,[1] Commissioner of Health of the State of New York, Karen

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[1] Barbara A. De Buono, M.D., successor to David Axelrod, M.D. and then Mark Chassin, M.D., as Commissioner of Health of the State of New York and Karen Schimke, successor to Lorna H. McBarnette, Executive Deputy Commissioner of Health, have been automatically substituted as parties pursuant to Fed. R. App. P. 43. The position of Deputy Director, Division of Health Care Financing, currently is vacant.

Schimke, Executive Deputy Commissioner of Health of the State of New York, and the Deputy Director, Division of Health Care Financing, Office of Health Systems Management (collectively referred to herein as the "State"), respectfully pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit, entered on January 4, 1996.[2]

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at 74 F.3d 28 (2d Cir. 1996) and reprinted in the appendix to the petition at 1a to 4a.[3] The order of the Supreme Court granting a writ of certiorari, vacating the judgment and remanding the case to the Second Circuit is reported at 115 S. Ct. 1819 (1995) and reprinted at 5a. The original opinion of the Second Circuit is reported at 27 F.3d 823 (2d Cir. 1994) and is reprinted at 6a to 14a. The memorandum opinion and order of the United States District Court for the Southern District of New York (Martin, J.) is not reported and is reprinted at 15a to 23a.

JURISDICTION

The judgment of the court of appeals was entered on January 4, 1996. This petition is filed within ninety days of the court's opinion. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1) (1994).

STATUTES INVOLVED

The applicable statutes are reproduced in the appendix at 27a to 28a. The relevant federal statutory provision is section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a). The relevant New York State statutes are N.Y. Pub. Health Law §§ 2801(1), 2807-d(1)(a), and 2807-d (2)(c).

[2] The caption of this case in this Court contains the names of all parties to the proceeding.

[3] References to the appendix attached to the petition are cited as "—a." References to the joint appendix filed in the Second Circuit are cited as "JA ——."

STATEMENT OF THE CASE

A. The Hospital Assessment

In 1990, in order to offset increased health care costs, the New York State Legislature enacted section 2807-d of the New York Public Health Law, referred to by the courts below as the Health Facility Assessment or "HFA." 1990 N.Y. Laws, ch. 938.[4] The assessment was enacted as an alternative to substantial Medicaid payment reductions which would otherwise have been required (JA 51, 59).

The assessment is charged to all "hospitals" which are defined to encompass generally any facility engaged in providing services under the supervision of a physician or dentist, and includes diagnostic centers and treatment centers. N.Y. Pub. Health Law § 2801(1) (McKinney 1993). The assessment, which is six-tenths of one percent for diagnostic and treatment centers, applies with limited exceptions to a covered facility's gross receipts from patient care services and other operating income. N.Y. Pub. Health Law §§ 2807-d(1)(a), 2807-d(2)(c) (McKinney 1993). Assessable income has been further defined by the New York State Department of Health to include all cash receipts from patient care services irrespective of payment source, investment income, and other operating income, such as non-patient food sales, parking revenue, medical records fees, and the like (JA 65). Reports of assessable income and the assessments are required to be forwarded on a monthly basis to an administrative agent appointed by the New York State Depart-

[4] The assessment, as originally enacted, was to expire on April 1, 1992, but was amended to remain in effect after that date. 1995 N.Y. Laws, ch. 2, § 135.

ment of Health which, in turn, transmits those monies to the state's general fund (JA 57).

Respondents, trustees of the NYSA-ILA Medical and Clinical Services Fund (collectively referred to herein as the "Fund"), an ERISA employee welfare benefit plan, operate two medical centers in New York State. The medical centers are incorporated separately as New York not-for-profit corporations and are licensed by the New York State Department of Health as "diagnostic and treatment centers" pursuant to N.Y. Public Health Law § 2805 (JA 142-43). The centers provide medical, dental and related health care benefits on an outpatient basis to Fund participants and beneficiaries (JA 78-79). The medical centers also provide services to certain individuals who are not Fund participants, by virtue of an agreement between the medical centers and another employee benefit plan.

The medical centers' income is derived from a number of different sources, including employer contributions pursuant to collective bargaining agreements which are remitted to the Fund and transfered to the medical centers, employer contributions remitted directly to the medical centers, fee-for-service payments made directly to the medical centers by another ERISA fund, employee co-payments for services, fee-for-service payments from workers' compensation carriers, and miscellaneous sources such as supplier rebates and medical records fees (JA 80-82, 85).

The medical centers filed reports and paid assessments for the period from January 1, 1991 through November 30, 1991 (JA 84-85, 135-41). The centers did not include in their reported assessable income any monies which were transferred to them from the Fund reasoning that such income was akin to a grant which is non-assessable income under state law (JA 84). The State did not contest that exclusion. The centers reported as assessable income employer contributions to the centers,

contributions from workers' compensation carriers, fee-for-service payments from another ERISA fund, and employee payments for certain services, as well as miscellaneous income (JA 84). For the period from January 1, 1991 through November 30, 1991, the centers reported assessable income of $1,177,670 and paid assessments totaling $7,066.02 (JA 84-85). Thereafter, the centers discontinued filing reports and paid no further assessments (JA 86).

B. Prior Proceedings

On April 16, 1992, the Fund commenced this action for declaratory and injunctive relief and for a refund of the assessments already paid on the ground that the hospital assessment is preempted by ERISA (JA 18-23). The parties cross-moved for summary judgment pursuant to Fed. R. Civ. P. 56.

The district court granted the State's motion, determining that the hospital assessment is not preempted by ERISA because it is a law of general application with only an incidental economic impact on ERISA plans (21a).[5] Pointing to the *de minimis* amount of the assessment, the court distinguished this case from *The Travelers Insurance Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y.), *aff'd*, 14 F.3d 708 (2d Cir. 1993), *rev'd sub nom. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995), in which three New York State surcharges imposed on hospital bills of varying amounts of 9%, 11%, and 13%, depending on the identity of the third-party payor, were invalidated as ERISA-preempted (22a).

On June 23, 1994, the Second Circuit reversed the district court. The court stated that because "the HFA

[5] The district court did not reach the other issues raised by the State, namely, that the Tax Injunction Act, 28 U.S.C. § 1341 (1994), barred the complaint and that the claim for a refund is barred by the Eleventh Amendment to the United States Constitution.

targets only the health care industry" which is, "by definition, the realm where ERISA welfare plans must operate [the assessment] was bound to affect them" (12a). Thus, the court distinguished it from other laws of general applicability. Because the Fund had chosen to provide medical benefits through its own medical centers, the HFA operated as an immediate tax on payments and contributions which were intended to pay for medical benefits (12a).

Relying on its decision in *The Travelers Insurance Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1993), *rev'd sub nom. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995), the Second Circuit held that the assessment "relates to" the Fund directly by reducing assets otherwise available to provide health care benefits, thereby causing the Fund to reduce benefits provided or charge beneficiaries more (12a). According to the court, the impact of the assessment "will detrimentally affect the central mission and purpose of the Fund and hence cannot be characterized as remote and tenuous" (12a). Addressing the Fund's statement that it could avoid the tax altogether by funnelling all medical center income through the Fund, the court held that "such a restructuring would alter the Fund's established method of administraton" and would in itself be a basis for ERISA preemption (13a).

The State filed a petition for a writ of certiorari on October 21, 1994, after this Court granted the State's request for an extension of time within which to file the petition (26a). On May 1, 1995, this Court granted the petition, vacated the judgment, and remanded the case for further consideration in light of its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995) ("*Travelers*") (5a).

On January 4, 1996, the Second Circuit issued a decision which adhered to its original determination that the

HFA was preempted by ERISA insofar as it applies to the income of a medical center owned by an ERISA fund. The Second Circuit held that the facts of the case distinguish it from this Court's decision in *Travelers* because "there is no third party between the plan and the tax imposed pursuant to the HFA" (3a). Therefore, the statute "depletes the Fund's assets directly" (3a-4a). The court concluded its analysis by observing that "[n]othing in *Travelers* undermines our reliance on the HFA's direct economic impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of pre-emption" (4a).

REASONS FOR GRANTING THE WRIT

I. THE DECISION OF THE COURT OF APPEALS IS IN DIRECT CONFLICT WITH SUPREME COURT PRECEDENT

This Court vacated the prior judgment in this case and remanded it to the court of appeals for reconsideration in light of its opinion in *Travelers*. The Second Circuit, however, did not actually apply the *Travelers* analysis in the decision. Instead, the court simply distinguished this case from *Travelers* on the basis that "there is no third party between the plan and the tax" (3a). An actual application of the *Travelers* analysis in this case demonstrates that the Second Circuit's opinion on remand is in conflict with this Court's decision in *Travelers*. Moreover, the court's reliance upon the lack of a third party between the generally applicable hospital assessment and the Fund as the basis for preemption is in conflict with *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988). In *Mackey*, this Court held that a generally applicable garnishment statute was not preempted despite its direct imposition of legal obligations upon an ERISA plan which resulted in economic costs and administrative burdens to the plan.

In *Travelers*, this Court held that state laws which have only an indirect economic impact upon the choices made by ERISA plans with regard to the provision of benefits are not preempted by ERISA. Construing ERISA's preemption provision in light of its objective, "to avoid a multiplicity of regulation, in order to permit the nationally uniform administration of employee benefit plans," 115 S. Ct. at 1677-78, this Court held that state laws relate to plans and are preempted when they "mandate[] employee benefit structures or their administration," or provide "alternative enforcement mechanisms." 115 S. Ct. at 1678.

The Court found, however, that the challenged surcharges, which made Blue Cross a more attractive insurance alternative, only had "an indirect economic effect on choices made by insurance buyers, including ERISA plans." 115 S. Ct. at 1679. Such economic influence "does not bind plan administrators to any particular choice and thus function as a regulation of the ERISA plan itself." 115 S. Ct. at 1679. Thus, ERISA does not preempt state laws that have an impact "on the costs of benefits." 115 S. Ct. at 1679. This Court also noted that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." 115 S. Ct. at 1680.

The Second Circuit's original decision that the HFA is preempted rested upon three bases: first, that the HFA was unlike other laws of general applicability because it was health care regulation and therefore affected plans in "the realm where ERISA plans must operate," (12a); second, that the HFA directly depleted plan assets intended to provide health care benefits, (12a); and third, that a restructuring of the plan to avoid the tax would interfere with uniform administration of the plan

on an interstate basis, (13a). The first and third of these bases have since been explicitly rejected by this Court in *Travelers*. This Court found no congressional intent to have ERISA generally displace health care regulation, 115 S. Ct. at 1680, and also held that state laws do not relate to plans if they do not mandate plan decisions, even if the law's economic effect results in plans if they do not mandate plan decisions, even if the law's economic effect results in plans making different choices in different states. 115 S. Ct. at 1679.

The application of the *Travelers* analysis does not yield a different result in this case simply because the tax is applied to an ERISA plan-owned medical center and, therefore, the impact is characterized as "direct." In *Travelers*, this Court focused upon whether the surcharges' economic impact upon plans mandated benefits or structures, not upon whether the economic impact was directly or indirectly imposed upon plans. Like the surcharges in *Travelers*, the HFA does not bind plan administrators to a particular choice of how to provide benefits nor does it have anything other than an economic impact on plans.[6] The HFA arguably has an economic impact on a plan's decision to provide medical services in-kind, through a plan-owned medical center, rather than simply paying for medical services that plan participants have received elsewhere. However, in *Travelers*, this Court held that the surcharges were not preempted because they simply bear on the cost of benefits and the relative costs of competing insurance to provide them. The HFA, as it is applied to ERISA plan-owned medical centers, simply bears on the cost of benefits and the relative costs of competing *methods* to provide them.

Nothing in *Travelers* supports the conclusion that valid laws, such as the surcharges in *Travelers*, which indirectly

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[6] In fact, the tax has no economic impact on plan choices. Since the tax is imposed on all hospitals in New York, plans which do not own medical centers pay the tax as it is passed on as part of their participant's medical bills.

increase costs to plans through their application to third parties, become invalid when the plans happen to own or operate the third party. Indeed, the HFA is very similar to the 9% assessment in *Travelers* which is imposed upon the inpatient hospital costs paid by health maintenance organizations (HMOs). Under the Second Circuit's rationale, the 9% would be preempted if an HMO was owned by an ERISA plan. However, none of the reasons articulated by this Court for finding the 9% not preempted are in any way diminished simply because a plan chooses to own an HMO, rather than using the more usual method of purchasing its services.

The Second Circuit's decision rests solely on its characterization of the HFA as having a direct impact upon the Fund. This Court, however, has not construed ERISA as preempting laws simply because they directly operate upon plans. Even prior to *Travelers*, this Court, in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), upheld a Georgia garnishment statute that directly operated upon plans. Like the HFA, the garnishment law was one of general application, but when it applied to plans it directly regulated their administrative procedures and, as a result, imposed costs. As garnishees, plan trustees were required to become parties to state lawsuits. They were also subject to state substantive law concerning spendthrift trusts. 486 U.S. at 831. Yet this Court held that these administrative burdens and costs, which were the result of a direct application of the statute to plans, were not enough to trigger preemption. 486 U.S. at 831. Moreover, in *Mackey*, this Court noted that run-of-the-mill state lawsuits against ERISA plans for unpaid rent, etc. were not preempted by ERISA. 486 U.S. at 833. Like the HFA, those legal obligations are applied directly to ERISA plans as well. The Second Circuit's failure to apply the *Travelers* analysis, and its reliance on a factor which this Court rejected as a basis for preemption in *Mackey*, has resulted in a decision in conflict with these cases. The Court should grant certiorari to resolve those conflicts.

II. THE DECISION OF THE COURT OF APPEALS IS ALSO IN CONFLICT WITH A DECISION OF THE EIGHTH CIRCUIT.

The decision of the Second Circuit is also in direct conflict with the decision of the Eighth Circuit in *Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied sub nom. Boyle v. Smith*, 64 U.S.L.W. 3511 (March 18, 1996). In *Boyle*, the court found that a Minnesota provider tax on the gross patient revenues of hospitals is not preempted by ERISA. The statute contemplates that the tax will be paid by third party purchasers. It includes a pass-through provision that authorizes providers to transfer the expense as an addition to the amount due the provider pursuant to any provider contract. 68 F.3d at 1098 (citing Minn. Stat. § 295.582 (Supp. 1993)). The law also imposes direct obligations upon plans to pay the tax. It provides: "all third party purchasers of health care services . . . must pay the transferred expense." 68 F.3d at 1098 (citing Minn. Stat. § 295.582 (Supp. 1993)). Accordingly, no third party stands between ERISA plans and the legal obligation to pay the tax. Despite this, the court rejected a self-insured ERISA plan's challenge to the law.

In *Boyle*, the Eighth Circuit correctly examined the nature of the impact of the pass-through provisions of the law, rather than focusing on the direct or indirect source of the impact. First, the court correctly viewed the law as one of general application because the statute does not refer to ERISA plans, single them out for different treatment or apply to them differently than non-ERISA plans. 68 F.3d at 1101. Recognizing that the purpose of ERISA preemption is to permit nationally uniform plan administration, the Eighth Circuit examined the impact of the law on plan administration. The court held that the law only causes plans to pay more for healthcare services already covered. 68 F.3d at 1103. While it may add to the differences in the price of health care services from state to state, it will not require plans to be redesigned or

cause inefficiencies. 68 F.3d at 1105. With respect to the economic impact of the law, the Eighth Circuit cited this Court's *Travelers* decision extensively and noted that the impact of the surcharges in that case was much greater than Minnesota's 2% provider tax. 68 F.3d at 1108. Weighing these factors, the Eighth Circuit concluded that the law has only a tenuous, remote and peripheral impact on plans which did not warrant preemption.

The decision in *Boyle* cannot be reconciled with the Second Circuit's decision in this case. Both laws involve a generally applicable provider tax where, in certain situations, the legal obligation to pay the tax falls direcly on plans. In *Boyle*, the law had a direct impact on ERISA plans by requiring self-funded plans to pay the tax expense when transferred. The HFA has a direct impact on ERISA plans by requiring them to pay the tax when they own a medical center. In both cases there is a tax on payments which are the plan participants' medical benefits. Thus, both laws directly affect funds in their role as a provider of benefits. After application of an analysis consistent with *Travelers*, the Eighth Circuit correctly found the tax was not preempted. This Court should grant a writ of certiorari to resolve this conflict.

III. THIS CASE PRESENTS SUBSTANTIAL AND PRESSING QUESTIONS OF NATIONAL SIGNIFICANCE

This case is of great importance because it deals with the right of states to devise appropriate means to finance health care. In addition, the breadth of the Second Circuit's decision threatens all generally applicable laws which may apply to ERISA plan transactions in the health care field and beyond.

Providing comprehensive yet cost effective health care is an issue of national concern. Many states are exploring ways to address the problems of health care access,

equity in financing and coverage, and expenditure growth. One of the most pressing issues facing states seeking to ensure adequate health care coverage is how to pay for it and who will bear the financing burden. One method of financing the cost of health care is an assessment on hospitals or health care providers of the sort which New York State has enacted in N.Y. Pub. Health Law § 2807-d. At least fourteen other states utilize similar kinds of financing mechanisms.[7] Under the Second Circuit's reasoning, those states may not collect the tax from ERISA plan-owned medical facilities. They are not un-

[7] See Ala. Code §§ 40-26B-1, 40-26B-21 (1995) (imposing "providers of medical services privilege tax" on nursing facilities); Conn. Gen. Stat. § 12-263(b) (1994) (tax of 11% on "hospital gross earnings of each hospital"); Fla. Stat. Ann. § 395.7015 (West 1995) (imposing 1.5% assessment on annual net operating revenues of certain "health care entities"); Haw. Rev. Stat. § 346E-2 (1995) (taxes of 6% and 4% imposed on "nursing facility income" and "hospital income" respectively); Ill. Ann. Stat. ch. § 305 para. 5/5A-2 (Smith-Hurd 1993 & Supp. 1995) (assessment of 1.88% of "adjusted gross hospital revenue" of "each hospital provider"); Ky. Rev. Stat. Ann. § 142.303 (Michie 1995) (2.5% tax on gross revenues of providers "for the provision of hospital services"); Me. Rev. Stat. Ann. tit. 22, § 391 (West 1992 & Supp. 1995) (assessment of .15% of hospital's "gross patient service revenues"); Minn. Stat. Ann. § 295.52 (West 1991 & Supp. 1996) (2% tax on "gross revenues of each "hospital" and "health care provider"); Mont. Code Ann. § 15-60-102 (1995) ($2.80 "utilization fee" paid by each "nursing facility" for "each bed day in the facility"); N.H. Rev. Stat. Ann. § 84-A:2 (1991 & Supp. 1995) (tax "at a rate to be established by the legislature each biennium upon the gross patient services revenue of every hospital"); S.C. Code Ann. § 12-23-810 (Law. Co-op. Supp. 1995) (hospital tax based on total expenditures of each hospital as a percentage of total hospital expenditures state-wide); Utah Code Ann. § 26-36-105 (1995) (Medicaid Hospital Provider Temporary Assessment imposed on hospitals and surgical facilities); Vt. Stat. Ann. tit. 33, § 1953 (1991 & Supp. 1955) (4.02% "hospital assessment" imposed on each hospital's "audited gross inpatient revenues"); W.Va. Code Ann. §§ 11-27-9, 11-27-15 (1995) (health care provider tax of 2.5% of gross receipts on providers of "inpatient hospital services" and "outpatient hospital services").

common now and if the Second Circuit's decision stands, the number of such facilities surely will increase [8].

Preemption of provider taxes as they are applied to ERISA plan-owned providers could also threaten the validity of state regulatory schemes under federal law. As part of its 1991 amendments to the federal Medicaid Act, Congress explicitly authorized states to use taxes of general applicability, such as a sales tax extended to hospital charges, 42 U.S.C. § 1396a(t) (1994), and health care provider taxes, 42 U.S.C. § 1396b(w) (1994), as a means of raising revenue that qualifies for federal matching funds. However, an assessment must be broad based to qualify and an assessment is not broad based if it excludes any provider within a class. If a tax is not broad based, it must meet strict statistical parameters for a waiver or the entire tax is considered impermissible and the entire proceeds will be offset against a state's Medicaid expenditures resulting in a loss of federal matching funds.

The breadth of the Second Circuit's decision is sweeping. The assessment was invalidated because, the court stated, "there is no third party between the plan and the tax imposed pursuant to the HFA" (3a). Were this view to prevail there would be virtually no room for states to regulate transactions in which ERISA plans, among others, engage. While this case concerns a tax on a medical center owned by a plan, the court's analysis would logically require preemption of every state law regulating hospitals and other providers, to the extent they are imposed on ERISA plan-owned medical providers. For example, no third party stands between an ERISA plan-owned medical center and state imposed staffing requirements, rate regulation, medical and nursing standards, or sanitary condition regulations.

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[8] In New York City alone at least four other major union-affiliated ERISA funds operate diagnostic and treatment facilities similar to the ones involved in this case.

The Second Circuit's reasoning is not limited to ERISA plan-owned medical centers. ERISA plans own and operate day care centers, prepaid legal services plans and educational facilities. Thus, staffing requirements, safety requirements and sanitary requirements for plan operated day care centers might well be preempted. Interest on Lawyers Accounts ("IOLA") requirements imposed upon plan owned and operated prepaid legal services programs might well be preempted. Health and safety requirements imposed by the construction unions' plan-run training schools are also in jeopardy.

In addition, there is no third party between a plan and any generally applicable tax which is imposed upon ERISA plan transactions. Under this analysis real estate taxes paid by plans on plan-owned buildings, sales tax on items purchased by plans, day care licensing fees imposed upon plan-owned day care centers, unemployment taxes paid on behalf of plan employees and a host of other "direct" economic regulation are preempted.

In 1985, the Second Circuit warned that too expansive an interpretation of ERISA's preemption provision would result in a "fully insulated legal world that excludes these plans from regulation of any purely local transaction." *Rebado v. Cuomo*, 749 F.2d 133, 138 (2d Cir.), *cert. denied*, 472 U.S. 1008 (1985). The adoption and use of the Second Circuit's "direct impact" test to determine the scope of ERISA preemption will create such an insulated world and goes far beyond what Congress intended in enacting the preemption provision. The Court should grant the petition to review this important question.

CONCLUSION

For the foregoing reasons the petition for a writ of certiorari should be granted.

Respectfully submitted,

DENNIS C. VACCO
Attorney General of the
State of New York
120 Broadway
New York, N.Y. 10271
(212) 416-8707
Attorney for Petitioners

VICTORIA A. GRAFFEO
Solicitor General

PETER H. SCHIFF
Deputy Solicitor General

DANIEL F. DE VITA
Assistant Attorney General
In Charge of Labor Bureau

M. PATRICIA SMITH *
Assistant Attorney General
* Counsel of Record

Dated: New York, New York
April 3, 1996

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 1294—August Term 1993

On remand from Supreme Court
(Submitted November 15, 1995 Decided Jan. 4, 1996)

Docket No. 93-7221

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,
Plaintiffs-Appellants,

— v. —

DAVID AXELROD, M.D., in his capacity as New York State Commissioner of Health; LORNA H. MCBARNETTE, in her capacity as New York State Executive Deputy Commissioner of Health; STEVEN C. ANDERMAN, in his capacity as Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,
Defendants-Appellees.

Before: WALKER and JACOBS, *Circuit Judges*, and ZAMPANO, *District* Judge.*

PER CURIAM:

On June 23, 1994, we entered a judgment and filed an opinion, *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 27 F.3d 823, which reversed a summary judgment entered February 23, 1993 by the United States District Court for the Southern District of New York (John S. Martin, Jr., *Judge*). The district court had held that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, did not preempt New York's Health Facility Assessment ("HFA"), N.Y. Pub. Health Law § 2807-d, reasoning that the tax imposed by the HFA "is not great enough to pose a serious economic threat to the plan." In reversing, we held that the HFA directly affected and was therefore "related to" the Fund in its principal role as an employee welfare plan.

On May 1, 1995, the Supreme Court entered an order granting certiorari, vacating the judgment of this court, and remanding the case to us for further consideration in light of *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995), *rev'g* 14 F.3d 708 (2d Cir. 1994). *See Chassin v. NYSA-ILA Medical & Clinical Servs. Fund*, 115 S. Ct. 1819 (1995).

We ordered counsel for the parties to brief the issue of whether *Travelers* requires a different result in this case. Upon receipt of these briefs, we carefully reconsidered this case in light of *Travelers*. For the reasons that follow, we adhere to our original decision reversing the judgment of the district court.

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* Honorable Robert C. Zampano, United States District Judge for the District of Connecticut, sitting by designation. Judge Zampano retired shortly after oral argument was heard in this case. Accordingly, the appeal was decided by the remaining panel members pursuant to Section 0.14 of the Local Rules of the Second Circuit.

The undisputed facts in this case have been set forth both in the district court opinion and in our original opinion, and we therefore do not fully restate them here. The Trustees of NYSA-ILA Medical & Clinical Services Fund (the "Fund") brought this suit seeking a declaration that ERISA preempts New York Public Health Law § 2807-d to the extent that the HFA taxes contributions and other payments for health care benefits received by two medical centers operated by the Fund. On appeal, we found that the HFA directly "relates to" the Fund in that "[t]he tax depletes those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received." *Axelrod*, 27 F.3d at 827.

Upon reconsideration in light of the Supreme Court's holding in *Travelers*, we conclude that the ground upon which our earlier decision in this case rested remains undisturbed. *Travelers* involved a challenge to New York's imposition of a surcharge on hospital bills paid by commercial insurers and Health Maintenance Organizations but not on hospital bills paid by Blue Cross/Blue Shield insurers. The statute at issue in *Travelers* did not impose surcharges on ERISA plans themselves, but on insurance carriers providing health insurance coverage to the plans and their beneficiaries. The surcharge consequently raised costs to the patient, who remained liable for the balance of any bill an ERISA plan or insurance carrier refuses to pay. The Supreme Court concluded that "a law operating as an indirect source of merely economic influence on administrative decisions [by ERISA plans], as here, should not suffice to trigger preemption." *Travelers*, 115 S. Ct. at 1680.

The facts of the present case distinguish it from *Travelers*, because, unlike in *Travelers*, there is no third party between the plan and the tax imposed pursuant to the HFA. Rather, the statute at issue depletes the Fund's

assets directly, and thus has an immediate impact on the operations of an ERISA plan. As we observed in our original opinion, the HFA imposes "an immediate tax on payments and contributions which were intended to pay for participants' medical benefits . . . [and] thus directly affects the Fund in its principal role as an employee welfare benefit plan." *Axelrod*, 27 F.3d at 827.

Nothing in *Travelers* undermines our reliance on the HFA's direct economic impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of pre-emption. Because our reasoning is not inconsistent with the Supreme Court's opinion in *Travelers*, we adhere to our original disposition that reversed and remanded this case.

APPENDIX B

SUPREME COURT OF THE UNITED STATES

No. 94-745

MARK CHASSIN, *et al.*,
Petitioners,
v.
NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, ETC., *et al.*,

May 1, 1995

On petition for writ of certiorari to the United States Court of Appeals for the Second Circuit. The petition for writ of certiorari is granted. The judgment is vacated and the case is remanded to the United States Court of Appeals for the Second Circuit for further consideration in light of *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*. 514 U.S. —, 115 S.Ct. 1671, —— L.Ed.2d —— (1995).

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

No. 1294—August Term 1993

(Argued March 10, 1994 Decided June 23, 1994)

Docket No. 93-7221

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, By Its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,
Plaintiffs-Appellants,

—v.—

DAVID AXELROD, M.D., in his capacity as New York State Commissioner of Health; LORNA H. MCBARNETTE, in her capacity as New York State Executive Deputy Commissioner of Health; STEVEN C. ANDERMAN, in his capacity as Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,
Defendants-Appellees.

Before:

WALKER and JACOBS, *Circuit Judges*,
and ZAMPANO, *District Judge*.*

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* Honorable Robert C. Zampano, United States District Judge for the District of Connecticut, sitting by designation. Judge Zampano retired shortly after oral argument was heard in this case. Accordingly, the appeal was decided by the remaining panel members pursuant to Section 0.14 of the Local Rules of the Second Circuit.

WALKER, Circuit Judge:

The Trustees of NYSA-ILA Medical & Clinical Services Fund (the "Fund") brought this suit seeking a declaration that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, preempts New York Public Health Law § 2807-d to the extent the latter provision taxes contributions and other payments for health care benefits received by two medical centers operated by the Fund. The Fund now appeals from a judgment of the United States District Court for the Southern District of New York (John S. Martin, Jr., *Judge*) holding that ERISA does not preempt the state tax and granting summary judgment to defendant state health care officials. We reverse.

BACKGROUND

The Fund is an ERISA-regulated multiemployer, labor-management trust fund established through collective bargaining to administer an employee welfare benefit plan that provides medical, dental, and other health care services to ERISA plan participants, consisting primarily of longshore workers, and their dependents. The Fund provides these health care benefits through three medical centers that it owns and operates, two in New York and one in New Jersey. The centers provide treatment exclusively to plan participants and beneficiaries.

In 1990, the State of New York enacted a Health Facility Assessment ("HFA"), which imposed a tax on the gross receipts from patient care services and general operations of all hospitals in New York State. N.Y. Pub. Health Law § 2807-d. The HFA was enacted to help eliminate the State's budget deficit for the 1990-91 fiscal year. The HFA became effective January 1, 1991, and was supposed to expire on April 1, 1992, but has subsequently been amended to remain in force on and after that date. 1992 N.Y. Laws, ch. 41, §§ 54, 163. The HFA applies to a wide range of medical facilities, includ-

ing diagnostic and treatment centers such as the medical centers operated by the Fund. N.Y. Pub. Health Law § 2801(1). The amount of the assessment, which varies by type of facility, is six-tenths of one percent for the Fund's medical centers. *Id.* § 2807-d(2)(c). For purposes of the assessment, "gross receipts" are defined as "all monies received for or on account of hospital and health related services" with only limited exceptions. *Id.* § 2807-d(3)(c).

The Fund's medical centers receive income from a variety of sources. The bulk of their costs are covered by employer contributions remitted to the Fund which are then transferred to the centers on an as-needed basis to pay for the centers' payroll and other operating expenses. However, the centers obtain additional revenue from certain employer payments made directly to the centers, employee co-payments, other fee-for-service payments, patient registration fees, payments from workers' compensation carriers, and such miscellaneous sources as the sale of scrap or waste, fees for reproducing medical records, and supplier rebates. For the period from January 1, 1991 to November 30, 1991, the Fund's two New York medical centers reported combined assessable income of $1,177,670 and paid assessments totalling $7,066. The Fund discontinued filing HFA reports with the New York State Department of Health after November 1991 and has paid no assessments since that time.

The medical centers did not include in their assessable income monies transferred from the Fund to the centers, and the State defendants have not contested the exclusion of these payments in this case. However, the question of whether monies transferred from the Fund to the centers are assessable has never, to our knowledge, been litigated or definitively resolved. Since early 1992, the Fund has restructured its payment procedures so that certain employer contributions and registration fees that were formerly paid directly to the medical centers are now remitted to the Fund itself. The Fund believes that this

restructuring avoids the effect of the HFA, but is unwilling to redirect to the Fund all payments now received by the medical centers until this case has been decided.

The Fund instituted this suit in April 1992 asserting that ERISA preempts the HFA insofar as it imposes a levy on contributions and payments for health care benefits provided by the Fund. The Fund does not challenge imposition of the HFA on the centers' miscellaneous revenue earned from activities unrelated to the health care services provided to participants and beneficiaries, such as the income derived from the sale of scrap, records reproduction fees, and supplier rebates. The Fund sought declaratory and injunctive relief as well as restitution of a substantial portion of the HFA assesments it had previously paid.

On cross-motions for summary judgment, the district court ruled that the HFA is a tax of general application that is not preempted by ERISA because it has only an incidental impact on ERISA plans. The district court reasoned that the minimal tax imposed by the HFA "is not great enough to pose a serious economic threat to the plan which might trigger preemption." *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 92 Civ. 2279 (JSM), slip op. at 8 (S.D.N.Y. Feb. 18, 1992). Accordingly, the district court judgment dismissing the action and this appeal ensued. We review the district court's decision *de novo*. *See Westinghouse Elec. Corp. v. New York City Transit Auth.*, 14 F.3d 818, 821 (2d Cir. 1994).

DISCUSSION

ERISA was enacted in 1974 "to promote the interests of employees and their beneficiaries in employee benefit plans," including both pension and welfare plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). An "employee welfare benefit plan" is defined in the statute as

> any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . .

29 U.S.C. § 1002(1). The parties do not dispute that the Fund qualifies as an employee welfare benefit plan that fulfills its institutional mission by providing medical benefits directly to plan participants and their beneficiaries through Fund-operated medical centers.

One of ERISA's main objectives was to eliminate state regulation of employee benefit plans. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990); *Shaw*, 463 U.S. at 99 (quoting legislative history). To accomplish this, Congress enacted an express preemption clause that is "deliberately expansive." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987). It provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the law. 29 U.S.C. § 1144(a). The Supreme Court has observed that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw*, 463 U.S. at 96-97. Preemption thus applies even where a state law was not specifically designed to regulate the terms and conditions of employee benefits plans or does not relate to those subjects covered by ERISA, such as reporting, disclosure, and fiduciary responsibilities. *See Ingersoll-Rand Co.*, 498 U.S. at 137-39; *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990); *Shaw*, 463 U.S. at 98. Indeed, even where a state law has no express link to an employee benefit plan, it can be preempted " 'insofar as' the law applies to benefit plans in particular cases." *Morgan Guar. Trust Co. v. Tax Appeals Tribunal*, 80 N.Y.2d 44, 49 (1992) (quoting *Shaw*, 463 U.S. at 97 n.17).

ERISA preemption is not without limitations, however. The Supreme Court has recognized that ERISA preemption will not apply to state laws that "affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. When it announced this limitation, the Court "express[ed] no views about where it would be appropriate to draw the line," *id.*, but it has subsequently observed that this limitation will apply "with many laws of general applicability," *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 583 n.1 (1992). There are a number of cases that bear out this observation. *See, e.g., Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (generally applicable garnishment law not preempted); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (state law requiring one-time severance payment not preempted); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.) (state escheat law not preempted when applied to recover unclaimed ERISA plan benefits), *cert. denied*, 493 U.S. 811 (1989); *see also Matter of Dyke*, 943 F.2d 1435, 1447 (5th Cir. 1991) (collecting cases). Unfortunately, these decisions have provided no sure method for determining whether the HFA's impact on the Fund is too "tenuous, remote, or peripheral" to trigger ERISA preemption.

The State argues that the HFA is a state tax law of general application that affects ERISA plans only incidentially. According to the State, the HFA is no more directed at ERISA plans than laws implementing sales taxes, utility taxes, and gasoline taxes, and should thus be seen simply as a "cost of doing business" within the state. Relying on *Mackey* and *Aetna Life Ins. Co.*, the State contends that the HFA should not be preempted because it covers ERISA plans only by virtue of the plans' inclusion in a broader class of entities subject to regulation.

However, we believe that the HFA is distinguishable from these laws of general application. The HFA does not apply broadly to every sector of society in New York; nor does it apply to the Fund simply because it engaged in certain kinds of activities which any other member of society might engage in, such as purchasing gasoline or paying one's employees. Rather, the HFA targets only the health care industry. Because this industry is, by definition, the realm where ERISA welfare plans must operate, the HFA was bound to affect them. In a case such as the present one where the plan has chosen to provide medical benefits through self-run medical centers, the HFA operates as an immediate tax on payments and contributions which were intended to pay for participants' medical benefits. The HFA thus directly affects the Fund in its principal role as an employee welfare benefit plan. It does not touch the Fund only slightly on the outer limits of its plan activities; it affects the very operations and functions that make the Fund what it is, a provider of medical, surgical, and hospital care to its participants and their beneficiaries.

We thus conclude that the HFA "relates to" the Fund and does so in a very direct way. The tax depletes those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received. Both impacts will detrimentally affect the central mission and purpose of the Fund and hence cannot be characterized as remote or tenuous. *See Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 720 (2d Cir. 1993) ("[T]he surcharges here force ERISA plans to increase either plan costs or reduce plan benefits. Therefore, they have the requisite connection to ERISA."), *petition for cert. filed*, 62 U.S.L.W. 3625 (U.S. Mar. 9, 1994) (No. 93-1414); *E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir.) ("The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite.

This is the type of impact Congress intended to avoid when it enacted the ERISA legislation."), *cert. denied*, 112 S. Ct. 585 (1991).

Our decision would remain the same even if we assumed that the Fund could avoid the HFA by restructuring its finances so that funds formerly remitted by plan participants and employers directly to the medical centers would be remitted to the Fund which would subsequently transfer them to the centers. Wholly apart from whether the transmission of assets from the Fund to the centers could be taxed without running afoul of ERISA preemption, an issue we need not add and do not decide, such a restructuring would alter the Fund's established method of administration and would require it to implement procedures for its New York facilities that differ from those of its New Jersey facility. Moreover, these changes would not be insignificant since they would affect the Fund's primary means of collecting contributions and paying for benefits. A state law that "relates to" an ERISA plan is not saved from ERISA preemption by the fact that a plan could restructure its operations to avoid the impact of the state law. Requirements under state law that force plans to change their traditional methods of administration or to adopt different methods on a state-by-state basis are features of state regulation that ERISA was designed to prevent. *See FMC Corp.*, 498 U.S. at 59-60; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981); *National Carriers' Conference Comm. v. Heffernan*, 454 F. Supp. 914, 918 (D. Conn. 1978) (Newman, J.), *Compare Aetna Life Ins. Co.*, 869 F.2d at 147 (discounting Fund's complaint that it would need to make administrative and accounting adjustments in order to comply with state escheat law because the impact was not substantial enough).

The district court acknowledged that the HFA will directly impact the Fund by leaving less money for benefits, but determined that the magnitude of the impact was too insubstantial to trigger preemption since the tax rate

was only .6%. We do no agree with this reasoning. The magnitude of a statute's economic impact on employee benefit plans may enter the analysis where the statute's connection to the ERISA plan is otherwise insufficient for preemption. For example, a real estate gains tax that has only a peripheral connection to ERISA plans may still be subject to preemption if the high rate of tax has a substantial economic impact on a plan. *See Morgan Guar. Trust Co.*, 80 N.Y.2d at 51-53 (ten percent tax on gain from ERISA plan's sale of real property preempted because of direct impact on plan's administration and investment strategy). However, the converse is not true. A statute that "relates to" ERISA plans cannot escape preemption simply because the magnitude of the impact is thought to be insubstantial. Adopting such an approach would contravene the policy that underlies the preemption provision of protecting ERISA plans from state regulation and would open the door to endless litigation about what constitutes a "substantial" impact.

Travelers Insurance Co. v. Cuomo, supra, is not to the contrary. In that case, we held that New York surcharges on hospital rates were preempted by ERISA to the extent ERISA plans must pay surcharges. In the course of our analysis, we discussed Judge Martin's opinion in this case without criticizing it. However, we cited it only for the proposition that "*a substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play." 14 F.3d at 721. We did not endorse—and now expressly refuse to endorse—the converse proposition urged by the State: that a regulation which has a *de minimis* economic impact on ERISA plans may withstand preemption regardless of what plan operations it affects.

For the foregoing reasons, we reverse the judgment of the district court.

APPENDIX D

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES: JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,
Plaintiff,

-v.-

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; AND STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,
Defendants.

MEMORANDUM OPINION AND ORDER

JOHN S. MARTIN, JR., District Judge:

Plaintiff and defendants have moved for summary judgment. The central question presented by these motions is whether the Employment Retirement Income Security Program (ERISA), 29 U.S.C.A. §§ 1001-1461 (1985 & Supp. 1992), preempts the State of New York's Health Facility Assessment (HFA), N.Y. PUB. HEALTH LAW § 2807-d (McKinney Supp. 1992).

The HFA, a state tax of general application, is an assessment charged on gross receipts of hospitals. *Id.* § 2807-d(1). Plaintiff is an ERISA plan which operates medical centers for the benefit of its plan beneficiaries. New York currently applies the HFA to plaintiff's medical centers. Plaintiff claims that its medical centers should not be subject to the tax because ERISA preempts state laws, such as the HFA, which affect ERISA plans. Plaintiff also seeks to recover the tax it has thus far paid under the HFA.

Defendant's move for dismissal on grounds that the Tax Injunction Act, 28 U.S.C.A. § 1341 (1976), prevents this Court from ordering injunctive relief which interferes with a state tax plan. Defendants also move in the alternative for summary judgment on plaintiff's claims.

Defendants' motion for summary judgment is granted because ERISA does not preempt the Health Facility Assessment.

DISCUSSION

Defendants first question this Court's jurisdiction over this case. ERISA provides that actions concerning ERISA preemption of state laws shall be brought in the United States District Courts. 29 U.S.C.A. § 1132(e)(1). However, this jurisdictional grant is in conflict with a jurisdictional bar contained in the Tax Injunction Act (TIA). 28 U.S.C.A. § 1341 (1976). The TIA provides that "[t]he district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State." *Id.* The conflict is resolved, however, in light of ERISA's provision that "nothing in [this subchapter] shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulations issued under any such law." 29 U.S.C.A. § 1144(d). This provision prevents ERISA from superseding the TIA. *Retirement*

Fund Trust v. Franchise Tax Bd., 909 F.2d 1266 (9th Cir. 1990); *Ashton v. Cory*, 780 F.2d 816, 822 (9th Cir. 1986); *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280, 1283 (D. Conn. 1977); *In re Sterling Die Casting Co., Inc.*, 118 B.R. 205, 207 (Bkrtcy. E.D.N.Y. 1990); *see also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 104-05, 103 S. Ct. 2890, 2904 (1983).

Plaintiff raises additional arguments against the TIA's applicability to this action which are unpersuasive. The Fund urges this Court to use rules of statutory construction to find that ERISA supersedes the TIA. Plaintiff notes that a more specific statute overrides one that is more general. *Morgan v. Mancari*, 417 U.S. 535, 550-51 (1974). However, the *Morgan* rule only applies where there is no clear expression by Congress as to whether the later statute is intended to supersede the earlier one. *Id.* This rule is inapplicable in this case because of the clear language of ERISA § 1144 which indicates that Congress did not want ERISA to affect other Federal law.

Plaintiff also argues that it should be allowed the benefit of an exception to the TIA. The Supreme Court has ruled that the United States is not restricted by the TIA from protecting itself and its instrumentalities from unconstitutional state exactions in federal courts. *Department of Employment v. United States*, 385 U.S. 355, 358 (1966). The Court extended this rule to allow Indian tribes an exemption from the TIA if the United States could have sued on their behalf. *Moe v. Confederated Salish and Kootenai Tribes*, 425 U.S. 463, 96 S. Ct. 1634 (1976). *Moe* grants this exception to Indian tribes in part because of the unique trustee relationship of the United States to the tribes. *Id.* at 473, 96 S. Ct. at 1641; *Federal Deposit Ins. Corp. v. State of New York*, 928 F.2d 56, 60 (2d Cir. 1991). Plaintiff misconstrues *Moe* to state that any private party is exempt from the TIA's jurisdictional bar if the United States could have sued on its behalf. *Federal Deposit Ins. Corp.*, 928 F.2d at 60. Since plaintiff is not

in a trust relationship with the United States, the *Moe* exception to the TIA does not apply in this action.

There being no reason extrinsic to the TIA to bar its application to this action, it is now appropriate to consider the terms of the TIA itself. The TIA operates to bar federal courts from granting injunctions or declaratory judgments in matters affecting state tax schemes when there is a "plain, speedy and efficient remedy" to be had in state courts. *Keleher v. New England Tel. & Tel. Co.*, 947 F.2d 547, 549 (2d Cir. 1991).

Plaintiff's arguments to the contrary notwithstanding, the HFA does fall within the class of state taxes excluded from the district courts' jurisdiction. For TIA purposes, the Second Circuit broadly defines the word "tax." *Keleher*, 947 F.2d at 549. Any state or local revenue collection device is a "tax" for purposes of the TIA. *Id.* (citing Robinson Protective Alarm Co. v. City of Philadelphia, 581 F.2d 371, 374-76 (3d Cir. 1978)). In the case at bar, the HFA is a revenue collection device of the state and is therefore a tax for TIA purposes.

Once it has been established that a state tax if at issue, federal courts do not have jurisdiction to enjoin its enforcement or declare it invalid if there is a plain, speedy and efficient remedy available in the state courts. 28 U.S.C.A. § 1341. It is not enough that the defendant may raise the invalidity of the tax as a defense to an enforcement proceeding. *Georgia R.R. & Banking Co. v. Redwine*, 342 U.S. 299, 303 n.11, 72 S.Ct. 321, 324 n.11 (1952); *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280, 1283 (D. Conn. 1977).

In New York State Courts, there are two affirmative proceedings that the taxed entity might pursue; an Article 78 proceeding and an action for declaratory judgment. However, where constitutional questions are implicated in an Article 78 proceeding, the proper procedure is for the action to be converted to one for declaratory judgment

because an Article 78 proceeding is not an appropriate forum for constitutional challenges. *Board of Educ. v. Gootnick*, 427 N.Y.S.2d 777 (N.Y. 1980). Thus, in New York, an action for declaratory judgment is the only action available to the Fund to affirmatively challenge the constitutionality of the HFA.

Plaintiff asserts, however that its claim will be dismissed in state court because ERISA grants exclusive jurisdiction over ERISA claims to the federal courts. Yet, plaintiff's speculation on the fate of its action in the state courts is discredited in light of the fact that New York State courts regularly entertain such actions. *See, e.g., Matter of Morgan Guar. Trust Co. v. Tax Appeals Tribunal*, 587 N.Y.S.2d 252 (N.Y. 1992); *Tap Elec. Contracting Serv., Inc. v. Harnett*, 556 N.Y.S.2d 988 (N.Y. 1990); *Sasso v. Vachris*, 494 N.Y.S.2d 856 (N.Y. 1985); *United Health Servs., Inc. v. Upstate Admin. Servs., Inc.*, 573 N.Y.S.2d 851 (N.Y. Sup. Ct. 1991); *People v. Art Steel Co., Inc.*, 505 N.Y.S.2d 715 (N.Y. Crim. Ct 1986). Nevertheless, courts have held that the uncertainty over whether New York State courts will entertain ERISA preemption actions renders the availability of a state court remedy anything but "plain." *Travelers Ins. Co. v. Cuomo*, No. 92 Civ. 3999 (LJF) (S.D.N.Y. Feb. 3, 1993); *Heffernan*, 440 F. Supp. at 1283. There is no need to decide this issue, here however, because, reaching the merits of plaintiffs, claim, I conclude that the HFA is not preempted by ERISA.

Since there are no disputed issues of material fact, this case is an appropriate one to resolve on motion for summary judgment. This case is governed by recent Second Circuit pronouncements on the extent of ERISA preemption. Although the parties make much of analogizing to, and discrediting, the Second Circuit's holding in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008, 105 S. Ct. 2702 (1985), that case does

not provide the clearest guidance. The Circuit Court has since refashioned its test for ERISA preemption in light of Supreme Court rulings subsequent to *Rebaldo*, although it has not abandoned *Rebaldo*. *See Rogers v. Consolidated Rail Corp.*, 948 F.2d 858 (1991); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir. 1989), *cert. denied*, 493 U.S. 811, 110 S. Ct. 57 (1989).

While ERISA's preemption provision is to be interpreted broadly, the presumption against preemption of state law is at its strongest when dealing with a law that is within the states' traditional police powers. *Rogers*, 948 F.2d at 859; *Aetna*, 869 F.2d at 144. The Second Circuit, in conducting a survey of ERISA preemption cases has generalized from them to find that there are certain types of cases which fall on either side of the preemption line. *Aetna*, 869 F.2d at 145-46. The Circuit Court found

> that the laws that have been ruled preempted are those that provide an alternative cause of action to employees to collect benefits protected by ERISA, refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee. Those that have not been preempted are laws of general application—often traditional exercises of state power or regulatory authority—whose effect on ERISA plans is incidental.

Id. at 146. Further defining "what constitutes an incidental impact," the Circuit Court stated that indirect economic impact alone was not enough. The impact must affect the "primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit." *Id.*

Using this litmus test, the Second Circuit held in *Aetna* that a Connecticut escheat law was not preempted by ERISA. *Id.* at 147. The escheat law required that pen-

sion benefits which remained unclaimed for more than twenty years be paid to the state. ERISA had no provision for what to do with the unclaimed benefits. The court recognized that the state escheat law would have an economic impact on the benefit plan and that administrative and accounting adjustments would have to be made to comply with the state law. However, the Circuit Court held that "these indirect and administrative effects are not substantial enough [ ] to persuade us that this is the type of law that Congress intended to preempt." Thus, "[a]bsent more specific direction from Congress, we can safely assume that Congress did not intend to create an exception to this traditional exercise of state authority." *Id.*

In the case at bar, this Court is confronted with the question of ERISA preemption of a state's tax law, a traditional exercise of state authority. The HFA is a tax of general application; it is not specifically directed at ERISA plans but applies to all health care facilities. The tax does not interfere with the calculation of benefits or the determination of an employee's eligibility for benefits. The impacts on benefit plans are incidentally economic resulting only in the need for administrative and accounting procedures to comply with the law.

The fact that the tax will leave less money for benefits is not decisive here as it was not in *Aetna*, where Connecticut's escheat laws also drained funds that might otherwise go to benefits. The tax is not great enough to pose a serious economic threat to the plan which might trigger preemption. *See Aetna, 869 F.2d at 147.* Here the tax is "sixth-tenths of one percent of each facility's gross receipts received from all patient care services and other operating income on a cash basis." N.Y. PUB. HEALTH LAW § 2807-d(2)(c). The Fund paid, for the period of January 1 through November 30, 1991, $7,066.02 as the assessment on $1,177,670 of income which is subject to the assessment out of approximately $20,000,000

(twenty million) total income for 1991. Fier Affidavit ¶ 19. While there are no numerical standards established by case law to determine how much tax is too much, it is clear that the HFA is not significant enough to warrant preemption of a state's traditional taxing power without explicit instructions from Congress.

Plaintiff notes that the New York Court of Appeals has reached a different conclusion. *Morgan*, 587 N.Y.S.2d 252. The Court of Appeals held that a state tax on gains from the transfer of real property was preempted by ERISA because it drained plan funds, caused an administrative burden that would be different than that in other states, and impacted the structure of administrative decisions on the disposal of assets. *Id.* at 256-57. However, *Morgan* is distinguishable from the case before this Court. The tax in *Morgan* was ten percent (10.0%) of the consideration received for the property sold, an amount the Court of Appeals considered significant, *Id.* at 257, as opposed to six-tenths of one percent (0.6%) in the case before this Court. The economic impact of the HFA is not as substantial as that found in *Morgan*. *Compare Travelers Ins. Co. v. Cuomo*, No. 92 Civ. 3999 (LJF) (S.D.N.Y. Feb. 3, 1993) (state surcharges of 9%, 11%, and 13% on hospital rates preempted by ERISA to the extent that ERISA plans must pay the surcharges).

Thus, it is consistent with decisions of the New York Court of Appeals, the Second Circuit, and District Courts within it, to hold that ERISA does not preempt the HFA.

Therefore, plaintiff's motion for a refund of the approximately $7,000 paid as HFA assessments is dismissed.

CONCLUSION

Defendants' motion for summary judgment dismissing the complaint is granted because ERISA does not preempt the Health Facility Assessment. Accordingly, the

remainder of defendants' and plaintiff's motions are dismissed as moot.

SO ORDERED.

Dated: February 18, 1993
New York, New York

/s/ John S. Martin, Jr.
JOHN S. MARTIN, JR.
U.S.D.J.

APPENDIX E

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES: JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,
Plaintiff,

-against-

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; AND STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,
Defendants.

JUDGMENT

Plaintiff and defendants having moved for summary judgment, and the said motions having come before the Honorable JOHN S. MARTIN, U.S.D.J., and the Court thereafter on February 23, 1993, having handed down its memorandum opinion and order (#71096); granting defendants' motion for summary judgment dismissing the complaint because ERISA does not preempt the Health Facility Assessment, and dismissing as moot the remainder of defendants' and plaintiff's motions, it is,

ORDERED, ADJUDGED AND DECREED: That defendants' motion for summary judgment dismissing the complaint be and it is hereby granted, and it is further,

ORDERED, that the complaint be and it is hereby dismissed because ERISA does not preempt the Health Facility Assessment, and it is further,

ORDERED, that the remainder of defendants' and plaintiff's motions be and they are hereby dismissed as moot.

DATED: New York, New York
March 1, 1993

/s/ James M. Parkison
Clerk

APPENDIX F

SUPREME COURT OF THE UNITED STATES

No. A-180

MARK CHASSIN, *et al.*,
Petitioner

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, *et al.*

ORDER

UPON CONSIDERATION of the Application of counsel for the petitioner,

IT IS ORDERED that the time for filing a petition for a writ of certiorari in the above-entitled case, be and the same is hereby, extended to and including October 21, 1994.

/s/ Clarence Thomas
Associate Justice of the Supreme
Court of the United States

Dated this 14th day of September, 1994

APPENDIX G

STATUTES

29 U.S.C. § 1144. Other Laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefits plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

* * * *

N.Y. Pub. Health Law § 2801(1)

* * * *

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility

which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings.

* * * *

N. Y. Pub. Health Law § 2807-d. Hospital assessments

1. (a) Hospitals, as defined in this article, excluding hospitals specified in paragraph (b) of this subdivision, are charged assessments on their gross receipts from all patient care services and other operating income, less pesronal needs allowances and refunds, on a cash basis in the percentage amounts and for the periods specified in subdivision two of this section. Such assessments shall be submitted by or on behalf of hospitals to the commissioner or his designee.

* * * *

2. (c) For al other facilities issued an operating certificate pursuant to section twenty-eight hundred five of this article, including diagnostic and treatment centers, the assessments shall be six-tenths of one percent of each facility's gross receipts received from all patient care services and other operating income on a cash basis beginning January first, nineteen hundred ninety-one for hospital or health-related services, including diagostic and treatment center services.

* * * *

Supreme Court, U.S.
FILED
MAY 2 1996
CLERK

(3)

No. 95-1594

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

vs.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS and PETER VICKERS,

Respondents.

On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Second Circuit

RESPONDENTS' BRIEF IN OPPOSITION

THOMAS W. GLEASON
ERNEST L. MATHEWS, JR.*
GLEASON & MATHEWS, P.C.
26 Broadway, 17th Floor
New York, New York 10004
(212) 425-3240

C. PETER LAMBOS
DONATO CARUSO*
LAMBOS & JUNGE
29 Broadway, 9th Floor
New York, New York 10006
(212) 943-2470

Co-Counsel to Respondents
*(*Counsel of Record)*

26pp

Rule 29.6 Statement

In accordance with Sup. Ct. R. 29.6, respondents state that none of them has a corporate parent, subsidiary, or affiliate.

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No. 95-1594

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

vs.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS and PETER VICKERS,

Respondents.

On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Second Circuit

RESPONDENTS' BRIEF IN OPPOSITION

Introduction

Petitioners ask this Court to entertain review of a circuit court's decision on remand that reconsidered and reaffirmed its earlier determination in the wake of an intervening decision of this Court. They quibble with the correctness of the Second Circuit's application of this Court's recent decision in

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671 (1995), *rev'g* 14 F.3d 708 (2d Cir. 1994) (hereinafter "*Travelers*"), to the factual context presented by this case. Flyspecking remand decisions of federal courts of appeals does not qualify as the type of special and important function that warrants the exercise of certiorari jurisdiction, *see* SUP. CT. R. 10, since this Court does not sit as a court of errors and appeals to pass judgment on every determination of inferior tribunals. The Second Circuit's decision in this case is eminently sound and perfectly compatible with the law of ERISA pre-emption articulated by this Court not only in *Travelers* but also in the long line of decisions that preceded it. Review by this Court, therefore, is unwarranted. The petition for certiorari should be denied.

Statement of the Case

This case involves the imposition by the State of New York pursuant to N.Y. PUB. HEALTH LAW § 2807-d (McKinney 1993 & Supp. 1996) of a tax upon contributions and payments for medical benefits provided to plan beneficiaries, which are paid to medical clinics operated in New York by an employee welfare benefit plan. The court of appeals previously ruled that this New York tax was pre-empted by the Employee Retirement Income Security Act ("ERISA"). *See NYSA-ILA Medical & Clinical Serv. Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994) (hereinafter "*Axelrod*"). On May 1, 1995, this Court granted certiorari, vacated the prior *Axelrod* decision, and remanded the case for further consideration in light of the *Travelers* decision. *See Chassin v. NYSA-ILA Medical & Clinical Serv. Fund*, 115 S. Ct. 1819 (1995).

Travelers

Travelers involved a challenge by a group of commercial insurance carriers and their trade association to invalidate New York's system of imposing surcharges on hospital bills paid by commercial insurers and Health Maintenance Organizations but not on hospital bills paid by Blue Cross/Blue Shield insurers. *Travelers*, 14 F.3d at 712. The surcharge scheme was designed to enhance artificially the

competitiveness of the latter group of insurers *vis-à-vis* the former. The Second Circuit had concluded that ERISA § 514, 29 U.S.C.A. § 1144 (West 1985 & Supp. 1996),[1] pre-empted New York's hospital rate-setting system because that state law (1) purposely interfered with the choices ERISA plans make for health care coverage and (2) substantially increased the cost to ERISA plans of providing health care benefits to their beneficiaries. *Id.* at 719-20. The court of appeals found that the hospital rate-setting system in *Travelers* related to ERISA plans, the statutory touchstone for pre-emption, because it had a connection with ERISA plans.[2]

---

[1] In 1974 Congress enacted ERISA, a comprehensive regime to protect the interests of employees and their beneficiaries in private employee benefit plans. *Shaw v. Delta Air Lines*, 463 U.S. 85, 90 (1983); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990); *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 127 (1992). ERISA's "crowning achievement" was the elimination of state regulation of ERISA plans. *Shaw*, 463 U.S. at 99. Congress fostered this objective by adopting a "deliberately expansive" express pre-emption clause, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987), that is "conspicuous for its breadth," *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). The clause, ERISA § 514(a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C.A. § 1144(a) (West 1985).

[2] The controlling test for determining whether a state law meets the "relate to" standard of ERISA § 514(a) is simple and direct: every state law that has a connection with or reference to an ERISA employee benefit plan relates to that plan and is pre-empted, whatever the state law's underlying purpose and intent. *Greater Wash. Bd. of Trade*, 506 U.S. at 129-130; *FMC Corp.*, 498 U.S. at 58-59; *Shaw*, 463 U.S. at 96-97. The "relate to" standard must be interpreted broadly, *see Shaw*, 463 U.S. at 98; it must be given a "broad common sense meaning," *see Ingersoll-Rand*, 498 U.S. at 139. The "relate to" touchstone does not limit ERISA pre-emption only to state laws specifically designed to regulate the terms and conditions of employee benefit plans or those dealing with the subjects of regulatory concern covered by ERISA — reporting, disclosure, fiduciary responsibility, and the like. *Ingersoll-Rand*, 498 U.S. at 137-39; *Shaw*, 463 U.S. at 98. Pre-emption prevails even if the state law is not specifically designed

(Footnote continued)

The connection in *Travelers*, however, was indirect because the surcharges were imposed not upon ERISA plans themselves but upon insurance carriers providing health insurance coverage to the plans and their beneficiaries. It was this indirect feature which prompted this Court to reverse the Second Circuit's determination. This Court concluded that "a law operating as an indirect source of merely economic influence on administrative decisions [by ERISA plans], as here, should not suffice to trigger pre-emption . . . ." *Travelers*, 115 S. Ct. at 1680.

It would appear that *Travelers* may have "reconfigured the landscape for ERISA preemption." *New England Health Care Union, District 1199 v. Mount Sinai Hospital*, 65 F.3d 1024, 1029 (2d Cir. 1995).[3] The Court eschewed any strict reliance on the conspicuously broad "relate to" test found in ERISA's pre-emption provision. "We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress

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to affect ERISA plans or the state law's connection, reference, or effect is only indirect, *see Greater Wash. Bd. of Trade*, 506 U.S. at 129-130; *Ingersoll-Rand*, 498 U.S. at 139; *Pilot Life*, 481 U.S. at 47-48, or the state law is "consistent with ERISA's substantive requirements," *see Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).

[3] Since the *Travelers* Court expressly acclaimed its "fidelity to the views expressed in our prior opinions on the matter [of ERISA pre-emption]," *see* 115 S. Ct. at 1683 (citations omitted), it is debatable whether *Travelers* signals a lasting change in the Court's ERISA pre-emption jurisprudence or merely a temporary, but expedient, digression designed only to achieve the policy objective of preserving the integrity of state hospital rate-setting endeavors. *See* 115 S. Ct. at 1681-82. A paraphrase of Circuit Judge Ralph K. Winter's remark in another case is brought to mind: "I hope that all further references to this decision will be accompanied by the words, 'That case is easily distinguishable; it involved . . . [hospital rate-setting]'"! *United States v. International Bhd. of Teamsters*, 948 F.2d 98, 111 (2d Cir.) (Winter, J., dissenting), *vacated as moot*, 113 S. Ct. 31 (1992).

understood would survive." *Travelers*, 115 S. Ct. at 1677. Analysis of ERISA's legislative history led the Court to conclude that "[t]he basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 1677-78. So long as the state law does not require "mandated employee benefit structures or their administration," establish "alternate enforcement mechanisms," or "preclude uniform administrative practice or the provision of a uniform interstate benefit package," it does not give rise to "those 'conflicting directives' from which Congress meant to insulate ERISA plans." *Id.* at 1678, 1679, 1680 (citations omitted).

The key analytical tool for determining ERISA pre-emption, in the *Travelers* Court's view, is the intent of Congress, as expressed in the language of the pre-emption provision and its legislative history.

> While Congress's extension of pre-emption to all "state laws relating to benefit plans" was meant to sweep more broadly than "state laws dealing with the subject matters covered by ERISA[,] reporting, disclosure, fiduciary responsibility, and the like," nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.

Id. at 1680 (citations omitted). In reaching this conclusion, the *Travelers* Court was impressed by other Congressional enactments adopted after ERISA's passage, some by the same Congress, which were simply incompatible with ERISA pre-emption of state legislation regulating hospital rate-setting. *See id.* at 1681-82 & n.6.

Against this analytical backdrop the *Travelers* Court ruled that the New York surcharge laws, which have "only an indirect economic effect on the relative costs of various health insurance packages . . . [and] leave plan administrators right where they would be in any case, with the responsibility to

choose the best overall coverage for the money . . . do not bear the requisite 'connection with' ERISA plans to trigger pre-emption." *Id.* at 1680. In the Court's view, the indirect economic effects of the challenged surcharge laws do not regulate any ERISA plan itself because they do not bind plan administrators to any mandated choice nor preclude any uniform administrative practice or uniform interstate benefit package. *Id.* at 1679. An indirect economic influence "simply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges." *Id.* at 1679.

Post-*Travelers* Decisions of the Courts of Appeals

The *Travelers* Court prescinded from the question whether the surcharge statute was pre-empted by ERISA insofar as it applies to self-insured funds. *Id.* at 1675 n. 4.[4] In the wake of *Travelers*, the Second Circuit and four other circuits had occasion to consider the ramifications of the *Travelers* ruling on the law of ERISA pre-emption.[5] None of these cases broke

[4] The Court's approach was consistent with the views expressed in the brief filed in *Travelers* by the United States at the Court's request. It was the indirect effect of the surcharge statute in *Travelers* which led the United States to recommend the issuance of a writ of certiorari in *Travelers* to enable the Court to decide the question whether ERISA pre-empts state laws "of general applicability that have only an indirect, economic effect on ERISA plans." Brief for United States As Amicus Curiae at 8, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (filed Sept. 1994). The United States acknowledged that the direct application of state law to ERISA plans would present entirely distinct issues not present in *Travelers*. *Id.* at 14-15

[5] *See Greenblatt v. Delta Plumbing & Heating Corp.*, 68 F.3d 561 (2d Cir. 1995); *Connecticut Hospital Ass'n v. Weltman*, 66 F.3d 413 (2d Cir. 1995); *New England Health Care Union, District 1199 v. Mount Sinai Hospital*, 65 F.3d 1024 (2d Cir. 1995); *NYS Health Maintenance Organization Conference v. Curiale*, 64 F.3d 794 (2d Cir. 1995); *Travelers Ins. Co. v. Pataki*, 63 F.3d 89 (2d Cir. 1995), *on remand from* 115 S. Ct. 1671

(Footnote continued)

any new ground. State laws, like the surcharge statute at issue in *Travelers*, involving indirect economic effects on ERISA plans were saved from pre-emption; prevailing wage laws and death benefit laws having more immediate impacts upon ERISA plans were not.

The panels in three of the Second Circuit post-*Travelers* cases had occasion to comment on the prior *Axelrod* decision in this case, but their observations shed little light on whether the *Axelrod* decision retained its vitality in light of *Travelers*. All three panels seemed to be impressed by this Court's order vacating the prior decision in *Axelrod*, *see Weltman*, 66 F.3d at 415; *New England Health Care*, 65 F.3d at 1030, 1034; *Travelers-II*, 63 F.3d at 94 — a misplaced reliance, since vacatur is an unremarkable phenomenon that has no precedential value.[6]

One of the three panels properly refrained from predicting whether the Second Circuit's prior *Axelrod* decision in this case "remains good law." *See Weltman*, 66 F.3d at 415. Another, however, could not resist the temptation to resort to the

(1995) (hereinafter "*Travelers-II*"); *O'Shea v. First Manhattan Co. Thrift Plan*, 55 F.3d 109 (2d Cir. 1995); *Thiokol Corp. v. Roberts*, 76 F.3d 751 (6th Cir. 1996); *Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied*, 64 U.S.L.W. 3623 (Mar. 18, 1996) (U.S. No. 95-1163); *ABC Nat'l Line Erection Apprenticeship Training Trust v. Aubry*, 68 F.3d 343 (9th Cir. 1995); *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647 (7th Cir. 1995).

[6] This Court's vacatur and remand for further reconsideration in light of an intervening ruling by the Court is neither an adjudication on the merits nor an indication of this Court's sentiments. It represents adherence to the time-honored and routine practice of giving the circuit court the first crack at re-examining the case because this Court itself is "not certain that the case was free from all obstacles to reversal on an intervening precedent" and is not prepared at that juncture to address the merits. *See Henry v. City of Rock Hill*, 376 U.S. 776, 776-77 (1964) (*per curiam*) (citations omitted); *see also United States v. National Soc'y of Professional Eng'rs*, 404 F. Supp. 457, 459 & n.2 (D.D.C. 1975), *aff'd in part & remanded in part*, 555 F.2d 978, 982 (D.C. Cir. 1977), *aff'd*, 435 U.S. 679 (1978).

gratuitous obiter dictum that "in the wake of *Travelers* (and the Court's decision to vacate *NYSA-ILA*), we question whether we should continue to distinguish between laws that directly deplete ERISA plans' assets and laws that only indirectly do so." *See Travelers-II*, 63 F.3d at 94. But only the circuit court panel in this case, which had the benefit of both the pertinent record evidence and the views of those with a stake in the outcome of the controversy, was in a position to provide an informed answer to this question.

Decision Below

The answer given was short and to the point: "Upon reconsideration in light of the Supreme Court's holding in *Travelers*, we conclude that the ground upon which our earlier decision in this case rested remains undisturbed." *Axelrod*, 74 F.3d at 30. It took the court of appeals less than a page of analysis to reason that the *Travelers* decision of this Court, which limited its holding to "a law operating as an *indirect* source of merely economic influence on administrative decisions [by ERISA plans]," *see id.* at 30 (citing *Travelers*, 115 S. Ct. at 1680) (emphasis supplied), does not support shielding from ERISA pre-emption a statute like the New York tax at issue in this case which "depletes the Fund's assets *directly*, and thus has an immediate impact on the operations of an ERISA plan." *Id.* at 30 (emphasis supplied). Consequently, the court of appeals concluded that "[n]othing in *Travelers* undermines our reliance on the HFA's direct economic impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of pre-emption." *Id.* at 30.

Despite the apparent tension between the decision of the court of appeals in this case and comments made by other panels of the same circuit, neither rehearing nor rehearing *en banc* was sought. Instead, the petition for certiorari now before this Court ensued.

REASONS FOR DENYING THE WRIT

The Decision Below Does Not Deviate From The Mainstream of ERISA Pre-emption Law. *Travelers* In No Way Redeems From ERISA Pre-emption Direct State Taxation of Contributions Or Other Payments For Benefits Provided by An ERISA Plan.

The decision of the court of appeals in this case defines the law of ERISA pre-emption when the state law at issue *directly* affects an ERISA plan. The court of appeals determined that ERISA pre-empts the New York law in this case because that state enactment "imposes 'an immediate tax on payments and contributions which were intended to pay for participants' medical benefits . . . [and] thus directly affects the Fund in its principal role as an employee welfare benefit plan.'" *Axelrod*, 74 F.3d at 30, *reaffirming* 27 F.3d at 827. Neither this Court nor any other court has ever questioned the propriety of considering a state law's direct economic impact upon ERISA plans in adjudging whether the state enactment falls within the ambit of ERISA pre-emption. It is difficult to conceive of a state law that more clearly relates to ERISA plans than one which directly assesses contributions and other payments that fund the health care benefits provided to plan beneficiaries.

No Conflict With *Travelers*

The decision of the court of appeals in this case is perfectly compatible with established pre-emption jurisprudence, and nothing in the *Travelers* decision suggests otherwise. Indeed, in *Travelers* this Court expressly declined to abandon the principles enunciated in its prior ERISA pre-emption decisions and intimated its inclination to have found ERISA pre-emption if the state law at issue in *Travelers* had had a direct effect upon ERISA plans. *See Travelers*, 115 S. Ct. at 1683. ("That said, we do not hold today that ERISA pre-empts only direct regulation of ERISA plans . . . .").

Petitioners, when quoting and paraphrasing the teachings of *Travelers*, are constrained to mention the real focus of *Travelers* — a state law's "indirect economic effect" on ERISA plans. *See* Petition For Certiorari (hereinafter "Cert. Pet.") at 7-8. However, when forced to come to grips with the application of *Travelers* to the precise facts and issue in this case, petitioners have to resort to dissembling in order to concoct a conflict between *Travelers* and the decisions of the court of appeals in this case. They proffer an interpretation of *Travelers* that departs from its true holding. Petitioners argue, "In *Travelers*, this Court focused upon whether the surcharges' economic impact upon plans mandated benefits or structures, not upon whether the economic impact was directly or indirectly imposed upon plans." *See* Cert. Pet. at 9. *Travelers's* putative vitiation of the distinction between direct and indirect effects for ERISA pre-emption purposes somehow escaped the notice both of this Court in the *Travelers* decision itself and of every court that has examined the true scope and meaning of the *Travelers* decision. The Second Circuit has cogently identified the precise holding of *Travelers*: "Suffice it to say that a law's indirect economic effect on ERISA plans, in and of itself, generally will not trigger ERISA preemption." *New England Health Care*, 65 F.3d at 1030 (citations omitted). "The Court, though, left open or did not directly address a number of issues," *id.* at 1030, including the very issue presented for adjudication in this case: whether ERISA pre- empts a direct state tax on ERISA plan contributions and benefit payments.

Despite the precise and cabined holding of *Travelers*, petitioners suggest that it has produced a sea change in the law of pre-emption. They contend that *Travelers* stands for the proposition that any state law that has only an economic impact on ERISA plans is not pre-empted. *See* Cert. Pet. at 9. If petitioners' formulation, that for pre-emption purposes the distinction between direct and indirect effects should be vitiated, were to prevail, state laws regardless of whether they directly or indirectly affect ERISA plans would escape pre-emption, and there would be virtually no state law that would

yield to ERISA pre-emption — a result that would sap ERISA's pre-emption clause of all vitality.[7]

No Conflict With *Mackey*

Petitioners also attempt to fabricate a conflict where none exists between the decision below and *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988). The purported conflict rests upon an inaccurate interpretation of *Mackey's* holding. Petitioners contend that *Mackey* sustained against a claim of ERISA pre-emption "a generally applicable garnishment statute . . . despite its *direct* imposition of legal obligations upon an ERISA plan which resulted in economic costs and administrative burdens to the plan." *See* Cert. Pet. at 7 (emphasis supplied); *see also id.* at 10. But this Court in *Travelers* had a completely different understanding of its prior *Mackey* ruling. The *Travelers* Court noted that because *Mackey* had held that "a law authorizing an *indirect* source of administrative cost is not pre-empted, it should follow that a law operating as an indirect source of merely economic influence on administrative decisions, as here, should not suffice to trigger pre-emption either." *Travelers*, 115 S. Ct. at 1680 (emphasis supplied). *Mackey* adds nothing new or different to what *Travelers* supplied to the ERISA pre-emption calculus. Neither *Travelers* nor *Mackey* contains any principle, holding, or analysis that is at odds with the decision of the court of appeals in this case.

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[7] About the only state laws that would not escape pre-emption would be those that mandate plan decisions. Petitioners' formulation, however, is little more than a replay of approaches that have already been discredited, like limiting pre-emption to state laws that address the subjects of regulatory concern covered by ERISA — reporting, disclosure, fiduciary responsibility and the like — *see Ingersoll-Rand*, 498 U.S. at 137; *Shaw*, 463 U.S. at 98; or that specifically target ERISA plans, *Greater Wash. Bd. of Trade*, 506 U.S. at 129-130; *Pilot Life Ins. Co.*, 481 U.S. at 47.

No Intercircuit Conflict

Petitioners' penchant for false conflicts is not limited to decisions of this Court. Petitioners also play fast and loose with the decision of the Eighth Circuit in *Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied*, 64 U.S.L.W. 3623 (Mar. 18, 1996) (U.S. No. 95-1153), again resorting to whatever it takes to invent a conflict. Petitioners assert that the state health provider tax in *Boyle* "imposes direct obligations upon plans to pay the tax [because] [i]t provides: 'all third party purchasers of health care services . . . must pay the transferred expense.'" *See* Cert. Pet. at 11 (citations omitted). Petitioners conveniently omit the full text of the statutory passthrough provision without any designation of the ellipsis. The statute actually reads: "A hospital, surgical center, pharmacy, or health care provider that is subject to a tax under Section 295.52 may transfer additional expense generated by section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer . . . . All third-party purchasers of health care services . . . must pay the transferred expense . . . *to the extent allowed under federal law*." *See Boyle*, 68 F.3d at 1098 (quoting Minn. Stat. § 295.52 (Supp. 1993)) (emphasis of pertinent part of provision omitted by petitioners). Unlike petitioners in this case, the Minnesota Legislature well understands the limits federal ERISA pre-emption law establishes for direct state exactions upon ERISA plans. Moreover, "the passthrough is voluntary," *id.* at 1103 n. 2, not a state-mandated, direct imposition but an indirect economic effect that arises when the targets of the state tax decide on occasion to pass the tax onto their customers. *Id.* at 1103-1104.

No Discord With Prevailing ERISA Pre-emption Law

Travelers did not produce a wholesale rewriting of the law of ERISA pre-emption. The "relate to" standard found in ERISA's express pre-emption clause is still the governing touchstone, although the *Travelers* Court disfavored a slavish embrace of its literal words, preferring instead an examination

of all the surrounding circumstances, including the objectives of the ERISA statute, the language of its pre-emption clause, and the context of its legislative passage, to discern the type of state law Congress intended to displace. 115 S. Ct. at 1677, 1680.

Application of this Court's instructions in *Travelers* leaves no doubt that the decision of the court of appeals in this case is in perfect harmony with the prevailing law of ERISA pre-emption. The court of appeals heeded the admonition of the *Travelers* Court, that Congressional intent is the guide to determine what state laws are supplanted by ERISA pre-emption. The court below adhered to the Congressional directive that state tax laws of general application are not immune from ERISA pre-emption. Indeed, ERISA's pre-emption provision contains a clear and unambiguous statement of Congressional intent to include within ERISA's pre-emptive embrace "any State tax law relating to employee benefit plans." 29 U.S.C.A. § 1144(b)(5)(B)(i) (West 1985).[8] The conference report explained that this statutory directive assured that "preemption is continued with respect to . . . any state tax law relating to employee benefit plans . . . ." H.R. CONF. REP. No. 984, 97th Cong., 2d Sess. 18 (1982), *reprinted in* 1982 U.S.C.C.A.N. 4603. The comments on the Senate floor during its legislative passage reveal a Congressional understanding that ERISA pre-emption

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[8] When ERISA was first under legislative consideration in 1974, Congress underscored its objective of expansive pre-emption by rejecting a request by the Secretaries of Labor and Treasury to exclude state tax laws from ERISA pre-emption. *Northwest Airlines v. Roemer*, 603 F. Supp. 7, 12 (D. Minn. 1984). In 1983 Congress added a specific provision reaffirming that ERISA's pre-emption clause applied to state tax laws. 29 U.S.C.A. § 1144(b)(5)(B)(i) (West 1985). In light of this explicit Congressional design, "[t]he fact that a State tax law of general application is at issue is therefore not determinative of ERISA preemption." *Morgan Guar. Trust Co. v. Tax Appeals Tribunal*, 80 N.Y.2d 44, 51, 587 N.Y.S.2d 252, 256, 599 N.E.2d 656 (1992); *see also, E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir.), *cert. denied*, 502 U.S. 981 (1991).

would be triggered when state laws "relate to matters thoroughly regulated under ERISA or *impose tax liability on insurance premiums or benefits*." 128 CONG. REC. S26902 (daily ed. Oct. 1, 1982) (statement of Sen. Dole) (emphasis added).

There is a clear and unequivocal Congressional policy to shield ERISA plans from the destructive effects of state taxation. Congress has meticulously put into place throughout the Internal Revenue Code a national system of tax exemptions for ERISA plans. Contributions to ERISA plans are deductible and tax exempt. *See, e.g.*, 26 U.S.C.A. § 404 (West Supp. 1996) (pension and annuity plans); 26 U.S.C.A. §§ 162, 419, 419A (West Supp. 1996) (welfare benefit plans); 26 U.S.C.A. § 79 (West Supp. 1996) (employer-paid cost of life insurance); 26 U.S.C.A. § 106 (West Supp. 1996) (contributions to disability plans). Income earned through the investment of plans' assets is tax-free. *See, e.g.*, 26 U.S.C.A. §§ 501(a), 501(c) (West Supp. 1996) (pension and welfare plans).[9] Benefits received from welfare plans are tax-exempt. *See* 26 U.S.C.A. §§ 104, 105, 106 (West Supp. 1996) (accident and health benefits); 26 U.S.C.A. § 101 (West 1988) (death benefits); 26 U.S.C.A. § 129 (West Supp. 1996) (dependent care benefits). Benefits received from pension plans are tax-deferred; pension benefits are nontaxable while held by ERISA plans and only become taxable when ultimately received by the beneficiary. *See* 26 U.S.C.A. §§ 402, 403 (West Supp. 1996). ERISA's pre-emption clause preserves this uniform nationwide system of tax exemptions from the unsettling effects of conflicting state tax policy.

The court of appeals in this case applied the ordinary, commonsensical meaning of the statutory "relate to" standard and found that a state tax assessment levied upon employer

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[9] Of course, ERISA plans, like other employers, must pay payroll taxes (social security and federal unemployment taxes) attributable to individual workers in the plans' employ. *See infra pp.* 16-17.

and employee contributions to a medical center operated by an ERISA welfare plan to provide medical benefits to plan beneficiaries has a direct connection to the plan and is pre-empted not in its entirety but only insofar as it assesses those contributions. Indeed, every court that has addressed a state tax law that directly assesses plan contributions or plan benefits has found that the state enactment relates to ERISA plans and is pre-empted. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir.), *cert. denied*, 502 U.S. 981 (1991) (tax on health care benefits paid by plan); *General Motors Corp. v. California State Bd. of Equalization*, 815 F.2d 1305, 1309 (9th Cir. 1987), *cert. denied*, 485 U.S. 941 (1988) (tax computed on basis of health care benefits paid by plan); *Birdsong v. Olson*, 708 F. Supp. 792, 798-799, 801 (W.D. Tex. 1989), *appeal dismissed*, 901 F.2d 1270 (5th Cir. 1990) (tax on health care benefits paid by plan); *National Carriers' Conference Comm. v. Heffernan*, 454 F. Supp. 914, 917-18 (D. Conn 1978) (same).[10]

Congress understood the unique and fragile nature of employee benefit plans. It expressly included within the scope of

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[10] The only state tax laws that have survived ERISA pre-emption are business taxes imposed upon employers that include in the tax base contributions paid by employers to ERISA employee benefit plans, *see Thiokol Corp. v. Roberts*, 76 F.3d 751, 753-56 (6th Cir. 1996), and withholding and delinquency-garnishment procedures that assess not the plan but the beneficiary, *see Retirement Fund Trust of Plumbing v. Franchise Tax Bd.*, 909 F.2d 1266, 1281 (9th Cir. 1990); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 556 (6th Cir. 1987); *see also Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (monies subject to state garnishment had already been earmarked for judgment debtor so that application of state garnishment law did not affect amount of plan benefits due other beneficiaries); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) (same result for state escheat law). None of these state tax laws had any effect upon the amount of plan benefits or contributions, and thus their connection to ERISA plans was tenuous, remote, and peripheral — an insufficient nexus to trigger pre-emption. *Thiokol*, 76 F.3d at 754-55.

ERISA's pre-emption clause state tax exactions.[11] Anything less would have encouraged the various states to impose their individual tax levies upon the treasuries of ERISA plans. "The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation." *E-Systems*, 929 F.2d at 1103; *see also Northwest Airlines*, 603 F. Supp. at 12; *National Carriers' Conference Comm.*, 454 F. Supp. at 917.

The Congressional treatment of state tax laws within the context of ERISA pre-emption exposes the fallacy of the interpretation of *Travelers* propounded by petitioners. There are two separate and distinct reasons why *Travelers* does not stand for the proposition that state laws having only an economic impact on ERISA plans are not pre-empted. First, there is nothing in the *Travelers* decision that supports this reading. The ruling of the *Travelers* Court was limited to indirect economic impacts of an insubstantial nature. *See* 115 S. Ct. at 1683. Second, tax laws by their very nature have as their necessary effect a purely economic impact on the affected taxpayer. A state tax by definition, therefore, affects or relates to an ERISA plan because the tax imposes an economic exaction that the plan must pay. If, as petitioners suggest, economic impact alone could never trigger pre-emption, the explicit Congressional directive to include state tax laws that relate to ERISA plans within the reach of ERISA pre-emption could never be fulfilled. Adoption of the suggestion urged by petitioners would effectively read the directive out of the statute, a result that would violate basic principles of statutory construction. *See Travelers*, 115 S. Ct. at 1679-80.

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[11] Tax laws by their very nature are an intrusive form of government regulation. They mandate nothing but the payment of money. However, "the power to tax involves the power to destroy." *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 431 (1819).

To shield state tax enactments from ERISA pre-emption would be inconsistent with the basic "objectives of the ERISA statute" — a key guide to defining the scope of ERISA pre-emption. *Id.* at 1677. Subjecting ERISA plans to the taxing powers of 50 separate and distinct jurisdictions would frustrate the Congressional objective of allowing ERISA plans to adopt nationally uniform administrative practices and interstate benefit packages, which the *Travelers* Court identified as one of the principal goals of ERISA pre-emption. *See Travelers,* 115 S. Ct. at 1677-78. State taxation of plan benefits and plan contributions would be incompatible with this Congressional objective. Benefits would vary from state to state depending upon the magnitude of each state's tax bite. This Congressional objective is implicated in this very case. The New York tax at issue in this case has no New Jersey counterpart, thus requiring the NYSA-ILA Medical & Clinical Services Fund to restructure its established method of administration to implement procedures for its New York medical clinics that differ from those of its New Jersey clinic. *See Axelrod,* 27 F.3d at 828. "Requirements under state law that force plans to change their traditional methods of administration or to adopt different methods on a state-by-state basis are features of state regulation that ERISA was designed to prevent." *Id.* at 828 (citations omitted).

The court of appeals had little difficulty dispelling the wolf cry repeated in the petition to this Court, *see* Cert. Pet. at 14-15, that pre-emption of the assessment on contributions would shield ERISA plans from numerous other forms of state regulation which result in increases in the cost of doing business, such as unemployment taxes, sales taxes, utility costs, wage laws, staffing requirements, nursing standards, or sanitary regulations involving the disposal of medical wastes. These exactions and regulations affect ERISA plans as they do all others in society in their roles as employers, purchasers, and regulated businesses. The tax on contributions, however, affects ERISA plans *qua* employee benefit plans; it affects the very activities and functions that make employee benefit plans what they are. "It does not touch the Fund only slightly on the outer limits of its plan activities; it affects the very operations

and functions that make the Fund what it is, a provider of medical, surgical, and hospital care to its participants and their beneficiaries." *Axelrod*, 27 F.3d at 827. It was hardly remarkable, then, for the court of appeals to have concluded that Congress intended the express pre-emption clause of ERISA to proscribe state assessments that sap the lifeblood of ERISA plans and directly hinder their essential functions.

Petitioners' real quarrel is with Congress's policy of pre-empting state tax exactions. But this disagreement is not a justiciable controversy. Congress in its wisdom enacted in ERISA a pre-emption provision that deliberately protects ERISA plans from rapacious state taxes and other revenue-enhancing regulatory schemes. It is not the function of the Judicial Branch to override the policy decisions of the Legislative Branch. If Congressional policy is to be revamped, recourse must be sought in the halls of Congress, not in the chambers of this court.

The court of appeals in this case, as did every other tribunal that has entertained the same question, applied established precedent to invalidate the immediate and direct imposition of a state tax levy on contributions to, and benefit payments of, an ERISA plan. The decision below is perfectly consistent with the analytical methodology adopted by this Court in *Travelers*, since it gives effect to Congressional intent, the touchstone for ERISA pre-emption. The decision below rests squarely upon a clear and explicit Congressional policy to pre-empt state tax impositions on ERISA plan contributions and benefits and to discourage any state interference with nationally uniform administrative procedures and benefit packages. The decision below, therefore, is in perfect harmony with established principles of ERISA pre-emption law and should not be disturbed.

Conclusion

This case presents no conflict with Supreme Court precedent, no discord among the circuits, no departure from the prevailing law of ERISA pre-emption. Petitioners may quibble with the underlying Congressional policy that led to the enactment of an ERISA pre-emption provision that supplants direct state taxation of ERISA plans, but their dissatisfaction is not a valid ground for review by this Court of a court of appeals decision that complies with the directive embodied in established ERISA pre-emption jurisprudence as expressed by this Court in a long line of cases culminating in the recent *Travelers* decision — to give effect to the will of Congress in ERISA pre-emption cases. The petition for certiorari should be denied.

Dated: New York, New York
May 6, 1996

Respectfully submitted,

THOMAS W. GLEASON
ERNEST L. MATHEWS, JR.*
GLEASON & MATHEWS, P.C.
26 Broadway, 17th Floor
New York, New York 10004
(212) 425-3240

C.PETER LAMBOS
DONATO CARUSO*
LAMBOS & JUNGE
29 Broadway, 9th Floor
New York, New York 10006
(212) 943-2470

Co-Counsel To Respondents
*(*Counsel of Record)*

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,
Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

REPLY BRIEF OF PETITIONERS

DENNIS C. VACCO
Attorney General of the State of New York
120 Broadway
New York, N.Y. 10271
(212) 416-8707
Attorney for Petitioners

VICTORIA A. GRAFFEO
Solicitor General

PETER H. SCHIFF
Deputy Solicitor General

DANIEL F. DE VITA
Assistant Attorney General
In Charge of Labor Bureau

M. PATRICIA SMITH *
Assistant Attorney General

* Counsel of Record

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

No. 95-1594

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

v.

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REPLY BRIEF OF PETITIONERS

ARGUMENT

THE EFFECT OF NEW YORK'S HOSPITAL ASSESSMENT ON ERISA PLANS IS INDISTINGUISHABLE FROM THE EFFECT FOUND NOT TO BE PREEMPTED BY THIS COURT IN *TRAVELERS*.

Attempting to distinguish this case from *New York State Conference of Blue Cross & Blue Shield Plans v.*

Travelers, Inc. Co., 115 S. Ct. 1671 (1995) (*"Travelers"*), respondents argue that the hospital assessment in this case directly assesses contributions and other payments for medical benefits provided to plan beneficiaries, while the assessments in *Travelers* had indirect effects only (Resp. Br. 9-10). This argument misconstrues the state law and its affect on plans.

Section 2807-d of the Public Health Law imposes a 0.6 percent assessment on hospital income received from most sources, including for patient care services. 28-a.[1] The laws at issue in *Travelers* set hospital rates for all patients, imposed surcharges on certain rates, and imposed an assessment on health maintenance organizations ("HMOs"). N.Y. Pub. Health Law §§ 2807-c(1)(a), (b), (c), 2807-c(2-a). The effect on ERISA plans in both instances is identical because none of these laws apply to the plans themselves. The hospital rate setting statute in *Travelers* applies to all hospital bills; the HMO assessment applies to all HMOs; and the hospital assessment involved in this case applies to all hospitals. Because ERISA plans may provide hospital care benefits for their participants, the hospital assessment, like the laws at issue in *Travelers*, may increase the cost of providing such benefits to plans. Contrary to respondents' claim, however, that the assessment in this case "directly assesses contributions," (Resp. Br. at 9), that occurs, for any of these laws, only when ERISA plans pay for health care services for their participants.

This analysis is not affected by the facts of this case in which an ERISA plan owns and operates the medical center which is subject to the assessment. The assessment is imposed on hospital income, regardless of source. Thus, the effect on the plan here arises only as the result of a plan's payments to the hospital to provide benefits to participants. All hospitals receive a large portion of their income for patient care services from ERISA plans, so all

[1] References to the appendix submitted with the petition for a writ of certiorari are shown as "—a."

ERISA plans will be affected by the hospital assessment. The effect on a plan is the same whether or not it owns a hospital subject to the assessment.

The only difference between this case and a case involving a hospital not owned by an ERISA plan is simply the proportion of the hospital's total assessment which is paid by a single plan. In this case, because the hospital which is subject to the assessment is owned by an ERISA plan, all of the income subject to the assessment is paid by one plan. In fact, even in this case much of the income assessed comes from another ERISA plan, which has contracted with respondents to use the medical center. For a hospital which is not owned by an ERISA plan, the income assessed will come from a number of different ERISA plans. That difference, however, does not provide a principled basis for differentiating between the effect of this hospital assessment on this ERISA plan, the effect of this hospital assessment on other ERISA plans, or the effect of the hospital assessments in *Travelers* on plans subject to those assessments.

There is nothing in *Travelers* which supports a conclusion that an assessment on hospital income that does not relate to a plan which pays the assessment, but does not own the hospital, relates to a plan which pays the assessment when it or another plan owns the hospital. Nor can respondents effectively differentiate this case from *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988). In each case there was no third party between the legal obligation imposed by the state law and the plan. The source of the administrative cost was characterized as indirect in *Mackey*, because the state law imposed substantive legal obligations upon plans which in turn raised plan costs. Here, the law imposes a tax upon hospital income which in turn raises plan costs whether or not the plan which pays a participant's bill owns the hospital.

Respondents attempt to distinguish *Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied*, 116 S.

Ct. 1266 (1996), on the ground that in that case the 2% provider tax pass-through was voluntary. This ignores the fact that providing medical benefits through ownership of a hospital is also voluntary. In *Boyle*, once a pass-through occurs, the law imposes a legal obligation directly upon the plan to pay the tax. In this case once a plan chooses to own a medical center, the law imposes the obligation to pay the assessment.

Despite respondent's attempt to suggest otherwise, the standard for ERISA preemption of tax laws is no different than the standard for ERISA preemption of any other law. ERISA imposes no stricter preemption standards on state tax laws than on any other state law. Section 514 (b)(5)(B)(i) of ERISA, 29 U.S.C. § 1144(b)(5)(B)(i), simply provides that "any tax law *relating to* [ERISA] plans" is not exempt from preemption (emphasis added). Thus, the same "relates to" test of preemption which applies to state laws generally applies to state tax laws. This hospital assessment differs significantly from the laws involved in the cases relied upon by respondents (Resp. Br. at 5). In all of those cases, unlike the present case, the courts preempted state taxes or assessments because they referred to, or were directed specifically at, ERISA plans. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991); *General Motors Corp. v. California Bd. of Equalization*, 815 F.2d 1305 (9th Cir. 1987), *cert. denied*, 485 U.S. 941 (1988); *Birdsong v. Olson*, 708 F. Supp. 792, 798 (W.D. Tex. 1989); *National Carriers Conference Comm. v. Heffernan*, 454 F. Supp. 914 (D. Conn. 1978). These cases fit squarely within the Court's holdings which have preempted state laws which refer to, are predicated upon, or which function only through the existence of, ERISA plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580 (1992). The Court has never held, however, as respondents urge, that a law of general

application with only an economic impact on plans is preempted.

Finally, respondents attempt to distinguish the hospital assessment from other forms of generally applicable regulation such as sales tax, or unemployment tax, because it "affects ERISA plans *qua* employee benefit plans" (Resp. Br. at 17). This distinction, however, rests on a premise accepted by the Second Circuit in the original opinion in this case but subsequently rejected by the Supreme Court in *Travelers*, that health care regulation is to be treated differently than any other regulation under ERISA's preemption provision.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

DENNIS C. VACCO
Attorney General of the
State of New York
120 Broadway
New York, N.Y. 10271
(212) 416-8707
Attorney for Petitioners

VICTORIA A. GRAFFEO
Solicitor General

PETER H. SCHIFF
Deputy Solicitor General

DANIEL F. DE VITA
Assistant Attorney General
In Charge of Labor Bureau

M. PATRICIA SMITH *
Assistant Attorney General

* Counsel of Record

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In the Supreme Court of the United States

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BARBARA A. DE BUONO, NEW YORK STATE COMMISSIONER OF HEALTH, ET AL., PETITIONERS

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, ETC., ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

WALTER DELLINGER
Acting Solicitor General
EDWIN S. KNEEDLER
Deputy Solicitor General
JAMES A. FELDMAN
Assistant to the Solicitor General
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

J. DAVITT MCATEER
Acting Solicitor of Labor
ALLEN H. FELDMAN
Associate Solicitor
NATHANIEL I. SPILLER
Deputy Associate Solicitor
JUDITH D. HEIMLICH
Attorney
Department of Labor
Washington, D.C. 20210

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QUESTION PRESENTED

Whether a state tax on the "gross receipts received from all patient care services and other operating income" of hospitals licensed to operate in the State "relate[s] to" employee welfare benefit plans within the meaning of Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a), and is thus preempted, insofar as the tax applies to the income of medical centers owned and operated by an ERISA plan.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. In 1990, New York State enacted a tax, known as the Health Facility Assessment (HFA), in order to raise revenue and avoid reductions in the State's Medicaid program. Pet. App. 7a; C.A. App. 46, 51, 56, 59. With certain exceptions not relevant here, the assessment is imposed on all "[h]ospitals" operating in the State. The statute defines the term "hospital" to include a broad range of facilities that provide

health care services under the supervision of a physician or dentist, and expressly encompasses a "diagnostic center" and a "treatment center." N.Y. Pub. Health Law §§ 2801(1), 2807-d(1)(a) (McKinney 1993). The assessment is calculated as a percentage of the hospital's "gross receipts received from all patient care services and other operating income." *Id.* § 2807-d(1)(a).[1] The percentage differs for three types of hospitals, see *id.* § 2807-d(2)(a) to (c), but is assessed at 0.6% for diagnostic and treatment centers.

The law requires hospitals to make monthly payments of the assessment to the health commissioner or her designee, who remits the accumulated monies to the State's general fund. N. Y. Pub. Health Law § 2807-d(1)(a), (5), (7)(d) and (9) (McKinney 1993); see C.A. App. 60. Hospitals must also submit quarterly reports, and a certified annual report, of their gross receipts that are subject to the tax. N.Y. Pub. Health Law § 2807-d(7)(a) and (b) (McKinney 1993); see C.A. App. 60.

2. Respondents are the trustees of the NYSA-ILA Medical and Clinical Services Fund (Fund). The

[1] Receipts from "patient care services" refers to "all monies received for or on account of hospital or health-related services," including preadmission, out-patient, in-patient, and post discharge care, and items such as nursing service, ambulance service, laboratory service, medical social service, drugs, supplies, and room and board. N.Y. Pub. Health Law §§ 2801(4)(a) and (b), 2807-d(3)(c) (McKinney 1993). "Operating income" includes "monies received for or on account of such revenue sources as investment income, parking lots, cafeterias, gift shops and rental income," with certain exclusions. N.Y. Pub. Health Law § 2807-d(3)(d) (McKinney 1993); see C.A. App. 65.

Fund is a labor-management trust governed by Section 302 of the Labor Management Relations Act of 1947, 29 U.S.C. 186. The Fund was established pursuant to an Agreement and Declaration of Trust and Plan and collective bargaining agreements between the New York Shipping Association, Inc., and the International Longshoremen's Association covering longshore employment in the Port of New York and New Jersey. Pet. App. 7a; C.A. App. 19. The Fund administers a self-insured, ERISA-covered multi-employer welfare benefit plan, see 29 U.S.C. 1002(1) and (37); 26 U.S.C. 414(f), that provides medical, dental and other health services on an outpatient basis through three medical centers that it owns and operates. Pet. App. 7a. The two centers at issue here are located in New York and are licensed by the State to operate as diagnostic and treatment centers. Pet. 4; see N.Y. Pub. Health Law § 2805 (McKinney 1993); C.A. App. 43, 57, 83.

The centers principally serve longshore workers and retirees (and their dependents) whose labor contracts entitle them to receive health care at the centers. C.A. App. 78. The centers also provide services to members of other ILA locals who are employed by non-longshore employers ("outside employers") and whose contracts also entitle them to health care at the centers, *ibid.*; to members of the Port Police and Guards Union (PPGU) which, through its own ERISA-covered welfare plan (the NYSA-PPGU Welfare Fund), contracts with the NYSA-ILA Fund for the treatment of its members on a fee-for-service basis at the centers, C.A. App. 79, 81; and to local union officers and employees, *ibid.*

The centers receive income from a variety of sources. First, they receive payments directly from

Fund participants for annual registration fees and prescription co-payments. C.A. App. 76, 82, 143-144. Second, they receive payments from workers' compensation insurance carriers for services rendered to Fund participants injured on the job. C.A. App. 76, 82. Third, each of the centers receives contributions from nearby employers calculated on the basis of hours worked by Fund participants, as provided by labor contracts.[2] C.A. App. 76, 81. Fourth, the centers receive payments from the NYSA-PPGU Welfare Fund for services rendered to its participants on a fee-for-service basis. *Ibid.* Under the New York law, all of those categories of income constitute receipts from patient care services, and the HFA has been assessed against them. A fifth category of income—weekly remittances from the Fund for operating expenses on an as-needed basis—has not been subject to the assessment. C.A. App. 80.[3]

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[2] Although some employers send their contributions directly to the closest medical center, others (especially those who operate at more than one location) send their contributions to the Fund, which in turn funnels the money on an as-needed basis to the medical centers. C.A. App. 80-81; see note 3, *infra*.

[3] The remittances derive from employer contributions for Fund participants and contributions for local union officers and employees based on hours of work. C.A. App. 80-81. The Fund maintains that those remittances are akin to a grant that is non-assessable income under the New York law, Pet. 4 (citing C.A. App. 84), and the State has not attempted to apply the HFA to those monies. Pet. App. 8a; see *id.* at 13a. The assessability of remittances from the Fund to the centers is therefore not at issue in this case. *Id.* at 8a. Application of the assessment to operating income derived from such activities as records reproduction fees, which respondents do not challenge, is also not at issue. *Id.* at 9a.

From January through November 1991, the centers filed reports and paid the 0.6% assessment applicable to diagnostic and treatment centers on revenues the centers received for patient care services. Pet. App. 8a; see C.A. App. 143, 138.[4] Thereafter the Fund placed its assessments into escrow and ceased filing reports. Pet. App. 8a; C.A. App. 21-22. Beginning in 1992, payment of registration fees by Fund participants and service fees by the NYSA-PPGU Welfare Fund was redirected to the Fund instead of to the centers. Pet. App. 8a; C.A. App. 86.

3. In 1992 respondents brought this action to invalidate and enjoin enforcement of the HFA on the ground that it is preempted by Section 514(a) of ERISA, 29 U.S.C. 1144(a), "insofar as [the HFA] imposes a levy on contributions and payments for health care benefits provided by the Fund." Pet. App. 9a.[5] ERISA's preemption clause provides that ERISA supersedes all state laws that "relate to" an ERISA plan. 29 U.S.C. 1144(a).

On cross motions for summary judgment, the district court held that ERISA does not preempt the HFA.[6] Pet. App. 19a. Relying on *Aetna Life Ins. Co.* v. *Borges*, 869 F.2d 142 (2d Cir.), cert. denied, 493 U.S. 811 (1989), the court reasoned that the HFA is a tax law of general application because "it is not specifi-

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[4] For that period, the Fund paid $7,066 on assessable income of $1,177,670 (patient receipts and operating income). Pet. App. 8a; C.A. App. 84-85.

[5] Petitioners also sought "compensatory damages equal to the amounts paid to" the State, plus interest, costs and fees. C.A. App. 23.

[6] The district court did not reach the State's defenses under the Tax Injunction Act, 28 U.S.C. 1341, and the Eleventh Amendment. Pet. App. 19a.

cally directed at ERISA plans but applies to all health care facilities." Pet. App. 21a. The court observed that the tax "does not interfere with the calculation of benefits" or with "the determination of an employee's eligibility for benefits," and that the HFA's "impacts on benefit plans are incidentally economic resulting only in the need for administrative and accounting procedures to comply with the law." *Ibid.* The court also concluded that the economic impact of the 0.6% assessment is not substantial. *Id.* at 22a.

4. The court of appeals reversed. Pet. App. 6a-14a. It rejected the district court's conclusion that the HFA statute is a law of general application, because the HFA "does not apply broadly to every sector of society" in the State, but rather "targets only the health care industry," which, "by definition, [is] the realm where ERISA welfare plans must operate." *Id.* at 12a. Because the HFA "operates as an immediate tax on payments and contributions which were intended to pay for participants' medical benefits," the court stated, it "directly affects the Fund in its principal role" as a provider of health care benefits to plan participants and beneficiaries. *Ibid.* The court thus concluded that the HFA "relates to" the Fund because it "depletes those assets earmarked for the provision of health care benefits," and would cause the plan either to reduce benefits or increase charges. *Ibid.* In the court's view, those consequences would "detrimentally affect the central mission and purpose of the Fund," and therefore are not "remote or tenuous." *Ibid.*

Further, the court stated, it makes no difference that the Fund could avoid the HFA by "restructuring its finances so that funds formerly remitted by plan participants and employers directly to the medical

centers would be remitted to the Fund which would subsequently transfer them to the centers"; in the court's view, state laws "that force plans to change their traditional methods of administration or to adopt different methods on a state-by-state basis" are preempted by ERISA. Pet. App. 13a. Finally, the court concluded, a state law does not escape ERISA preemption merely because its economic impact on ERISA plans is de minimis. *Id.* at 14a.

5. This Court granted the State's petition for a writ of certiorari, vacated the judgment of the court of appeals, and remanded the case for further consideration in light of its intervening decision in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 115 S. Ct. 1671 (1995). Pet. App. 5a. The Court in *Travelers* held that New York statutes imposing 9%, 11%, and 13% surcharges on hospital care paid for by health maintenance organizations and commercial insurers did not "relate to" ERISA plans within the meaning of Section 514(a), and thus were not preempted. 115 S. Ct. at 1674. Determining that the surcharge statutes did not "make 'reference to'" ERISA plans, the Court analyzed whether they nevertheless had a "connection with" the ERISA plans. *Id.* at 1677; see *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). The Court observed that ERISA preempts state laws that "mandate[] employee benefit structures or their administration" or "provid[e] alternative enforcement mechanisms" for ERISA claims. 115 S. Ct. at 1678. Unlike those effects, the Court reasoned, the surcharge statutes had only "an indirect economic effect on choices made by insurance buyers, including ERISA plans." *Id.* at 1679. The Court noted that the surcharge statutes did not "bind plan administrators

to any particular choice and thus function as a regulation of an ERISA plan itself." *Ibid.* Nor, the Court reasoned, did the "indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform benefit package." *Ibid.* While the surcharges bore "on the costs of benefits," the Court concluded, *ibid.*, they did not produce such an "acute" economic effect "as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers," *id.* at 1683.

6. On remand from this Court, the Second Circuit adhered to its original decision in this case. Pet. App. 1a-4a. The court of appeals observed that the surcharges in *Travelers* were imposed not "on ERISA plans themselves, but on insurance carriers providing health insurance coverage to the plans and their beneficiaries." *Id.* at 3a. Those surcharges, the court stated, "raised costs to the patient, who remained liable for the balance of any bill" not paid by insurance or an ERISA plan. *Ibid.* Accordingly, the court stated, the surcharges "operat[ed] as an indirect source of merely economic influence" on plan decisions. *Ibid.*, quoting *Travelers*, 115 S. Ct. at 1680. The court distinguished the HFA on the ground that "there is no third party between the plan and the tax imposed pursuant to the HFA," so that the HFA "depletes the Fund's assets directly." Pet. App. 3a-4a. Thus, the court concluded, "[n]othing in *Travelers* undermines our reliance on the HFA's direct economic impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA

plans is sufficient for a finding of pre-emption." *Id.* at 4a.[7]

DISCUSSION

The court of appeals erred in holding that, when an ERISA plan chooses to engage in an economic activity in which a very broad group of other entities also engages and which is traditionally subject to state regulation, the plan is immune from state taxes that are imposed on that activity. The logic of that holding is inconsistent with this Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 115 S. Ct. 1671 (1995), and with the decision of the Eighth Circuit in a recent, post-*Travelers* case. For that reason, and because the decision below may have a serious impact on the ability of States in the Second Circuit to impose even-handed taxes and regulatory requirements on health care providers, further review by this Court is warranted.

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[7] The court of appeals' analysis on remand in the instant case was foreshadowed by its decision on remand in *Travelers*. This Court had remanded the case to the court of appeals to determine whether the 13% surcharge applicable to hospital bills incurred by members of "self-insured funds" was pre-empted. 115 S. Ct. at 1675 n. 4. On remand, the Second Circuit held that the 13% surcharge did not relate to "self-insured funds." *Travelers Ins. Co.* v. *Pataki*, 63 F.3d 89, 93-94 (1995). The court distinguished the HFA from the 13% surcharge on the ground that the HFA directly depletes plan assets, whereas self-insured plans are "not directly liable for the surcharge." *Id.* at 94. The court questioned, however, whether it "should continue to distinguish between laws that directly deplete ERISA plans' assets and laws that only indirectly do so." *Ibid.* In the court's decision on remand in the instant case, it did not cite to its remand decision in *Travelers*.

1. The Second Circuit held that the New York tax "relates to" the NYSA-ILA plan within the meaning of Section 514(a) of ERISA because the NYSA-ILA plan, as the owner of the medical center on which the tax is imposed, must directly pay the tax to the State. See Pet. App. 3a ("there is no third party between the plan and the tax"). That holding is inconsistent with the reasoning of this Court's decision in *Travelers*.[8]

First, the surcharge statutes upheld in *Travelers* and the tax at issue here are both "generally applicable statute[s]" that operate in an area of traditional state regulation and that "make[] no reference to, [and] indeed function[] irrespective of, the existence of an ERISA plan." *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 139 (1990).[9] The tax applies to all

[8] The United States stated in its amicus curiae brief at the petition stage in *Travelers* that "[a]pplication of the 13% surcharge to 'self-insured funds' *may* raise some distinct issues," not that it necessarily "*would* present entirely distinct issues," as respondents assert (Br. in Opp. 6 n.4; emphasis added). See Brief for the United States as Amicus Curiae at 14 n.5 in Nos. 93-1408, 93-1414 and 93-1415 (filed Sept. 14, 1994) (emphasis added); accord Brief for the United States as Amicus Curiae Supporting Petitioners at 12 n.3 in Nos. 93-1408, 93-1414 and 93-1415 (filed Nov. 15, 1994). The distinct issue we had in mind—but which was not before the Court—was whether the 13% surcharge payable by "self-insured funds" (but not other favored payors like Blue Cross/Blue Shield) singled out self-insured plans for special treatment and thus "relate[d] to plans" for that reason. Here, no such distinct analysis is necessary because the tax applies to hospitals generally and is entirely neutral with respect to ERISA plans.

[9] The HFA does not "refer to" ERISA plans. Indeed, if the HFA did expressly exempt plan-owned hospitals from the tax, which is the result respondents seek to achieve in this litigation, the exemption would be preempted as a law that "singles out ERISA employee welfare benefit plans for different treatment." See *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830, 838 n.12 (1988).

"hospitals" without regard to their ownership, their patient composition, or the ultimate source of patient revenues subject to the tax. Similarly, the surcharge statutes upheld in *Travelers* affect the hospital bills of all entities that pay for hospital care without regard to whether the payor is an ERISA plan, a commercial insurer, or a health maintenance organization. In both contexts, the state law has an effect on ERISA plans only because, and to the extent that, plans have chosen to engage in economic activity that is covered by the generally applicable law. That effect is "too tenuous, remote, or peripheral" to warrant a finding that the law "relate[s] to" ERISA plans. *Travelers*, 115 S. Ct. at 1680; *Shaw*, 463 U.S. at 100 n.21.

Second, the economic impact of the surcharge statutes in *Travelers* and the HFA on plans is the same. They both increase the cost of hospital care. Moreover, the increased cost resulting from both laws is paid from the accumulation of participant and employer contributions for plan benefits. Yet this Court in *Travelers* held that that sort of draw on plan assets does not suffice for preemption. See *Travelers*, 115 S. Ct. at 1679, 1681.

Third, application of other factors that the Court identified in *Travelers* as legally relevant to whether a state law "relate[s] to" ERISA plans reinforces the conclusion that the HFA is not preempted. The provider tax does not "mandate[] employee benefit structures or their administration," 115 S. Ct. at 1678, or impose any "substantive coverage requirement binding plan administrators," *id.* at 1681. While

the tax might cause the Fund's cost of providing hospital care to vary across state lines, that difference does not interfere with its ability to administer the plan uniformly on a multistate basis, *id.* at 1677-1678, and in any event, cost uniformity is not an object of ERISA preemption, *id.* at 1680. Nor is the economic effect of the tax so "acute" that it forces the Fund to "adopt a certain scheme of substantive coverage" or "effectively restrict[s] its choice" in the manner of providing benefits. *Id.* at 1681, 1683.[10] Thus, the HFA exhibits none of the characteristics of a state law that *Travelers* identified as warranting preemption.

We acknowledge that the Court in *Travelers* referred to New York's surcharge statutes in terms of their "indirect economic influence" on plan choices. 115 S. Ct. at 1679. But that was because the only question before the Court in *Travelers* was whether the surcharges—which were not directly paid by plans—were preempted. This Court has not suggested that the "direct" or "indirect" nature of a state law's effect on ERISA plans is dispositive of

[10] Indeed, the HFA has *less* effect on ERISA plans than the surcharges at issue in *Travelers*; because the HFA is set at a uniform, low rate (unlike the surcharges in *Travelers*, which varied among different types of health-care coverage providers), it was not designed to and will not have any effect on the choices of purchasers of health care (including plans) regarding what kind of health care to obtain. Once again, it is only if the court of appeals' decision is permitted to stand that the HFA would have an effect on plan choice, since in that event the effect of the HFA would be to encourage plans to set up their own hospitals rather than to provide hospitalization benefits in facilities owned by others. See note 9, *supra*.

whether the law relates to plans.[11] See *e.g.*, *id.* at 1678-1681. Moreover, while *Travelers* held that surcharge laws having only an "indirect" influence on ERISA plans are not preempted, this Court has recognized that laws whose "effect is only indirect" may also relate to plans and be preempted. *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. at 139; accord *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981); see *Travelers*, 115 S. Ct. at 1683. By the same token, this Court has held that ERISA does not preempt a generally applicable state garnishment law even as it applies to "participants' benefits in the hands of an ERISA welfare benefit plan." *Travelers*, 115 S. Ct. at 1680 (describing *Mackey* v. *Lanier Collection Agency & Serv., Inc., supra).* Thus, whether ERISA preempts a state law depends not on characterization of the law's effect as direct or indirect, but on the actual nature of the impact of the law on ERISA plans.[12]

[11] Respondents mischaracterize (Br. in Opp. 6 n.4) the United States' position in *Travelers*. In urging that the indirect economic effects of the New York surcharges were insufficient for ERISA preemption, we expressed the broader view that "[a] state regulation does not relate to plans so long as its only effect is to subject all buyers in a broad-based market in which ERISA plans and others substantially participate to a single set of marketplace incentives." Brief for the United States as Amicus Curiae Supporting Petitioners at 9 in Nos. 93-1408, 93-1414 and 93-1415 (filed Nov. 15, 1994). The United States never contended, as respondents here suggest, that the preemption analysis turns solely on the indirect or direct nature of the regulatory impact.

[12] Respondents contend (Br. in Opp. 10-11 & n.7) that if the direct economic effect of the tax on ERISA plans is held to be insufficient for preemption, no state law will be preempted except those that mandate plan decisions. That contention is

2. The Second Circuit's ruling that ERISA preempts the HFA insofar as it applies to a plan-owned hospital conflicts with the Eighth Circuit's decision in *Boyle* v. *Anderson*, 68 F.3d 1093 (1995), cert. denied, 116 S. Ct. 1266 (1996). That case concerned a Minnesota law that imposed a 2% tax on the gross patient revenues of hospitals and other health care providers. 68 F.3d at 1097-1098. The statute permitted the providers to transfer the cost of the tax to third-party purchasers of health care services, a category that included self-insured ERISA health plans. *Id.* at 1098. Hospitals passed the tax through in the form of increased charges for services, an itemized charge on the hospital bill, or a separate bill. *Id.* at 1098, 1104. The statute expressly provided that purchasers of health care services must pay the passed-through tax, even if their contracts with health care providers did not provide for such payments. See Minn. Stat. § 295.582 (Supp. 1993) ("[a]ll third-party purchasers of health care services * * * must pay the transferred expense in addition to any payments due under existing or future contracts with the hospital" or health care provider). Therefore, where the providers

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incorrect. While an exhaustive list is not possible, this Court has made clear that a law that has an economic effect would be preempted if it targets ERISA plans, *e.g.*, *District of Columbia* v. *Greater Washington Bd. of Trade*, 506 U.S. 125, 128 (1992); *Mackey*, 486 U.S. at 830, or if a state law produces such an "acute" economic effect that it "force[s] an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict[s] its choice of insurers." *Travelers*, 115 S. Ct. at 1683. A state law would also be preempted if it dictates the administration of plan benefit structures, or frustrates the "nationally uniform administration of employee benefit plans," or "provid[es] alternate enforcement mechanisms" to those contained in ERISA. *Id.* at 1678.

elected to pass-through the tax to ERISA plans, the state statute directly imposed on those plans the legal requirement to pay it.

A number of self-insured ERISA welfare plans challenged the pass-through of the 2% tax to their plans. *Boyle*, 68 F.3d at 1097. The Eighth Circuit held that, notwithstanding the requirement that the ERISA plans themselves had to pay the tax, ERISA did not preempt the state tax law. *Id.* at 1110. The court noted that the law applied generally to purchasers of health care, regardless of whether they were ERISA plans. *Id.* at 1101. The court further observed that the tax did not "negate a plan provision," "contradict any provision of ERISA," "alter[] relationships among the primary ERISA entities," or "change[] the plan structure." *Ibid.* The court also determined that the tax did not "impose an extra administrative burden" on ERISA plans other than subjecting them to "a minor difference in cost of services among the states." *Id.* at 1104. Moreover, the court reasoned, the "economic impact" on an ERISA plan of a law that merely increases the plan's cost of doing business does not "suffice for a finding of preemption." *Id.* at 1105; see *id.* at 1109. The court thus concluded that the Minnesota tax had "only a tenuous, remote and peripheral affect on the plans," and was not preempted. *Id.* at 1110.

Like the Minnesota tax, New York's HFA is generally applicable to all "hospitals" and is entirely neutral with respect to ERISA plans. Neither tax favors or discriminates against plans, affects plan terms, interferes with eligibility or benefit determinations, or dictates plan structure. The taxes merely increase the cost of hospital care to plans and non-plans alike. Moreover, the liability of ERISA plans for

payment of the tax is the same under both statutes: The tax is payable by ERISA plans to the extent they fall within the neutral category of taxed entities.

Contrary to respondents' assertion (Br. in Opp. 12), the circuit conflict is not obviated by distinguishing between the "direct" and "indirect" economic impact of the tax on "targets." In neither case does the tax on hospital revenues target ERISA plans, although in both cases ERISA plans are legally obligated to pay it. Nor can respondents distinguish *Boyle* (see *ibid.*) on the ground that the Minnesota statute requires purchasers of health care to pay the transferred expense only "to the extent allowed by federal law." Minn. Stat. § 295.52 (Supp. 1993). The holding of the Eighth Circuit in *Boyle* was that federal law allows the direct imposition of the tax on health care purchasers, a conclusion directly contrary to the conclusion reached by the Second Circuit in this case.[13]

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[13] The Second Circuit's reasoning—that the HFA relates to an ERISA plan because it constitutes "an immediate tax on payments and contributions which were intended to pay for participants' medical benefits" (Pet. App. 4a)—is also in some tension with two decisions of the Sixth Circuit. That court held that a city ordinance and a state law that imposed taxes calculated on a basis that included employee or employer contributions for health and other benefits provided by ERISA plans were laws of general application that were not preempted by ERISA. *Thiokol Corp.* v. *Roberts*, 76 F.3d 751, 753, 755 (1996), petition for cert. pending, No. 95-1913 (filed May 23, 1996) (2.35% state tax imposed on business tax base that included employers' payments to ERISA plans); *Firestone Tire & Rubber Co.* v. *Neusser*, 810 F.2d 550, 551, 554 (1987) (2% city tax imposed on earned income of city residents that included employee contributions for ERISA plan benefits); see also *Retirement Fund Trust of Plumbing, Heating and Piping Industry* v. *Franchise Tax Bd.*, 909 F.2d 1266 (9th Cir. 1990).

3. The issue in this case is of substantial importance. Under the Second Circuit's "direct economic impact" test, virtually every state law that taxes or regulates hospital care would be invalidated insofar as it applies to hospitals owned by ERISA-covered plans. For example, payment of generally applicable unemployment compensation taxes, payroll taxes, or real property taxes by a plan-owned hospital depletes plan assets at least as "directly" as payment of the provider tax at issue here. See *Boyle*, 68 F.3d at 1107; *Morgan Guar. Trust Co.* v. *Tax Appeals Tribunal*, 587 N.Y.S.2d 252 (N.Y. 1992) (ERISA preempts state tax on gain from property transfer when applied to transfer of plan-owned property). Similarly, state laws that impose quality control or workplace standards on hospitals have an impact on plans that own hospitals that is fully as "direct" as the impact of the provider tax. In both situations, the law's effect necessarily falls on the plan because the plan provides hospital care rather than purchasing it from "third party" providers in the marketplace. Indeed, if "directness" of a law's impact were the test of ERISA preemption, New York State's basic licensing laws could not survive, because they require "hospitals" to conform to state-approved systems of cost analysis, reporting and audits, and to maintain "premises, equipment, personnel, rules and by-laws, standards of medical care, and hospital service" that are "fit and adequate" according to state law.[14] N.Y. Pub. Health Law § 2805(1) and (2)(b) (McKinney 1993).

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[14] The breadth of the Second Circuit's decision is demonstrated by the court's decision to hold the HFA preempted as

Moreover, the court of appeals' reasoning leads to the conclusion that ERISA plans are exempt from a host of state laws that may tax or regulate the provision of other benefits and services that ERISA welfare plans provide rather than purchase. In addition to hospital and medical services, welfare benefits may include death benefits, day care services and prepaid legal services. 29 U.S.C. 1002(1); see 29 U.S.C. 186(c). Application of the court of appeals' "direct effect" test would invalidate, as applied to plan-owned service providers, state laws that tax client funds escrowed with attorneys, staffing requirements for day care centers, and embalming procedures for funeral homes. In short, the court of appeals' reasoning would lead to preemption of myriad state laws that constitute an otherwise valid exercise of a State's traditional police powers.

The principal teaching of *Travelers* is that "where federal law is said to bar state action in fields of traditional state regulation, [the Court has] worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" 115 S. Ct. at 1676 (citations omitted). Health care regulation is such a field of traditional state regulation, as *Travelers* emphasized. *Id.* at 1680. Because of the posture of the case decided in

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to *all* receipts for patient care by the Fund's centers—even when the Fund is merely acting like any other hospital in providing services to patients that are *not* paid for out of Fund assets. Thus, under the Second Circuit's decision, even when the Fund's hospitals treat patients who are not beneficiaries of the Fund (such as members of the PPGU) or whose care is paid for by workers' compensation, the income from those activities is immune from the HFA.

Travelers, however, the Court addressed only the question of whether indirect economic effects on plans as a result of the imposition of a state law of general applicability are sufficient to trigger ERISA preemption, and held that they are not. This case presents the question of whether direct economic effects of a like nature also do not "relate to plans" within the meaning of ERISA Section 514(a). That important issue warrants resolution by the Court.

4. This case need not be held pending the Court's disposition of *California Div. of Labor Standards Enforcement* v. *Dillingham Construction, N.A., Inc.*, No. 95-789 (to be argued Nov. 5, 1996). *Dillingham* presents the question whether ERISA preempts a state law requiring contractors on state public works projects to pay prevailing journeyman wages to apprentices unless the apprentices are enrolled in state-approved programs. In our amicus brief in *Dillingham* (at 10-22), we argue that the state law is not preempted because the employer may choose whether to provide apprenticeship training through apprenticeship programs that are ERISA plans or through apprenticeship programs that are not. Since the state law does not distinguish between those two types of programs or otherwise encourage or discourage employers to employ one rather than the other, we argue that it relates to the field of apprenticeship training—a subject of traditional state regulation—and not to ERISA plans.

There is a surface similarity between this case and *Dillingham*. In both cases, one of the primary entities subject to ERISA (the employer in *Dillingham*, the NYSA-ILA plan here) decided to take action (establishing an apprenticeship program in *Dillingham*, operating a hospital here) in an area tradition-

ally subject to state regulation. The entity thereby became subject to state laws of general applicability (the prevailing wage scheme and its requirements for state approval for apprenticeship programs in *Dillingham*, the HFA in this case) that operate in the area. In both cases, we argue that that consequence is insufficient to trigger ERISA preemption.

Notwithstanding that similarity, however, this Court's decision in *Dillingham* is unlikely to affect the Second Circuit's disposition of this case. The Second Circuit made clear in its decision on remand that in its view the HFA is preempted because the tax applies directly to ERISA plans that own hospitals. See Pet. App. 3a ("there is no third party between the plan and the tax imposed pursuant to the HFA"). The Second Circuit recognized that this Court's decision in *Travelers* established that similar taxes that had only indirect effects on ERISA plans are not preempted. See *ibid.* In *Dillingham*, the state law at issue applies to employers, not directly to ERISA plans, by regulating the wages that employers pay to apprentices (some of whom are enrolled in ERISA apprenticeship plans) under state public works projects. Accordingly, the Court in *Dillingham* may have no occasion to address the distinction that was crucial to the Second Circuit's decision in this case: the one between laws that directly apply to ERISA plans and those that indirectly affect them.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

WALTER DELLINGER
Acting Solicitor General

J. DAVITT MCATEER
Acting Solicitor of Labor

EDWIN S. KNEEDLER
Deputy Solicitor General

ALLEN H. FELDMAN
Associate Solicitor

JAMES A. FELDMAN
Assistant to the Solicitor General

NATHANIEL I. SPILLER
Deputy Associate Solicitor

JUDITH D. HEIMLICH
Attorney
Department of Labor

SEPTEMBER 1996

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No. 95-1594

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

BARBARA A. DEBUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF HEALTHCARE ASSOCIATION OF NEW YORK STATE AND AMERICAN HOSPITAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

MARK THOMAS
HEALTHCARE ASSOCIATION OF NEW YORK STATE
74 North Pearl Street
Albany, NY 12207

FREDRIC J. ENTIN
AMERICAN HOSPITAL ASSOCIATION
One North Franklin
Chicago, Illinois 60606

JEFFREY J. SHERRIN *
PHILIP ROSENBERG
SHERRIN & GLASEL
74 North Pearl Street
Albany, New York 12207
(518) 465-1275
Counsel for Amici Curiae

* *Counsel of Record*

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BRIEF OF HEALTHCARE ASSOCIATION OF NEW YORK STATE AND AMERICAN HOSPITAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

The Healthcare Association of New York State ("HANYS") and the American Hospital Association ("AHA") respectfully submit this brief as *amici curiae* in support of the petition for a writ of certiorari to the United States Court of Appeals for the Second Circuit.

Pursuant to Rule 37 of the Rules of this Court, the parties to this proceeding have consented to the request by HANYS and AHA to file a brief as *amici curiae*. Letters confirming their consent are being submitted with this brief to the Clerk of the Court.

INTEREST OF AMICI CURIAE

HANYS is a not-for-profit, tax-exempt trade association that represents over 220 public and private not-for-profit acute care general hospitals across the State of New York, as well as nursing homes, home health agencies, and other entities that are vitally interested in the preservation of a statewide system of comprehensive, readily-accessible, cost-effective and high quality health care. HANYS is the principal advocacy organization on behalf of New York's hospital industry and provides technical, administrative, legal and other services on behalf of its members.

Founded in 1898, the AHA is the primary national organization of hospitals in the United States. Its institutional members include approximately 80% of the nation's hospitals, and nearly 50,000 health care professionals hold individual membership. The AHA's corporate mission is to promote the quality of American health care for all people through leadership and assistance to hospitals and other health care organizations. To fulfill this mission, the AHA regularly participates in the judicial and legislative arenas to address important issues concerning federal and state health care reform in general and hospital regulation in particular.

HANYS and AHA support the Petition for a writ of certiorari to review the decision of the United States Court of Appeals for the Second Circuit that held that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, preempts a health care facility assessment ("HFA") under New York Public

Health Law § 2807-d to the extent it is applied to a hospital corporation established and operated by a self-insured employee benefit plan governed by ERISA. We seek review by this Court because the Second Circuit decision, while addressing a specific assessment against a limited class of hospitals, has implications that are much more far-reaching.

As leaders in the health care field, and as representatives of health care providers whose continued survival and service to society depend on equitable regulation, apportionment, and reimbursement of necessary costs, HANYS and AHA are vitally concerned that states retain the flexibility to assure equal access to affordable, high-quality health care, a goal that will be undermined if the decision of the Second Circuit Court of Appeals is permitted to stand. In light of the recent failure of Congress to enact comprehensive health care reform legislation, and uncertainties as to the future of such federal initiatives, it is likely that the states will be the primary venue of continued reform efforts. New York State has long been an innovative leader in attempting to provide affordable and quality health care to all of its residents.

SUMMARY OF ARGUMENT

The Second Circuit held in this case that ERISA bars a state from applying its general hospital gross receipts tax to hospitals operated by ERISA plans, resting its decision on the ground that the tax "depletes the Fund's assets directly, and thus has an immediate impact on the operations of an ERISA plan." *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 74 F.3d 28, 30 (2d Cir. 1996). In doing so, the court considered the decision of this Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995) [hereinafter *Travelers*], to be irrelevant, saying that:

> [n]othing in *Travelers* undermines our reliance on the [New York law's] direct economic impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of pre-emption.

NYSA-ILA Medical & Clinical Servs. Fund, 74 F.3d at 30. According to the Second Circuit, the *Travelers* decision is controlling only with respect to laws having an *indirect* economic effect on ERISA plans, and not to laws having a *direct* economic effect. *Id.*

This decision merits review for several reasons. Foremost, it is a serious misapplication of the principles set forth in *Travelers*. There, this Court concluded that a general state law was not preempted merely because it imposed costs on an ERISA plan, noting that any other view would lead to the "unsettling result" that "all laws with indirect economic effects on ERISA plans are pre-empted . . . ." *Travelers*, 115 S. Ct. at 1681. But, while the Second Circuit seized on the word "indirect" in distinguishing *Travelers*, it would be equally unsettling to conclude that all laws with *direct* economic effects on ERISA plans are preempted. Whether costs are imposed directly or indirectly, ERISA plans cannot claim an exemption from general laws regulating the provision of health care except, as noted in *Travelers*, to the extent that the laws can be found to conflict with the objectives of ERISA itself. It is *not* an objective of ERISA, however, to protect ERISA plans from any and all costs—direct or indirect—imposed by general state laws. *See Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied*, 116 S. Ct. 1266 (1996); *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382, 383 (1993).

The Second Circuit's analysis requires review by this Court because, if accepted, it would have wide-ranging

national consequences. If direct regulation of a hospital or health care system is preempted whenever it is operated by an ERISA plan, then it would follow that those facilities are free to disregard any state law regulating hospitals and other providers, including sanitary and staffing rules. But it was, in part, this very same prospect that prompted this Court to uphold the various surcharges at issue in *Travelers*, observing that disruption of general health care regulation could not have been the intent behind ERISA. *Travelers*, 115 S. Ct. at 1679-80. That conclusion does not change with the form of the charge, and the decision below would thus create a serious and unjustified impediment to the ability of states to regulate the provision of health care within their borders.

These consequences are so dramatic that the *amici* will explain first what these consequences are, and then why the Second Circuit rationale is so inconsistent with *Travelers*.

ARGUMENT

I. THE ISSUES IN THIS CASE ARE OF CONSIDERABLE NATIONAL IMPORTANCE.

This case raises issues of enormous consequence to the traditional regulation of health care. The Second Circuit's sole reason for distinguishing this Court's decision in *Travelers* was that the costs of the laws challenged in *Travelers* were only "indirectly" borne by ERISA plans, whereas the HFA was "directly" imposed upon such plans.[1] *NYSA-ILA Medical & Clinical Servs. Fund*, 74 F.3d at 30 ("[U]nlike in *Travelers*, there is no third party between the plan and the tax imposed pursuant to the HFA. Rather, the statute at issue depletes the Fund's assets directly . . . ."). But if a state regulation is preempted simply because it increases a plan's costs without

[1] The direct/indirect dichotomy is not limited to health care and, therefore, raises similar implications with respect to other arenas in which ERISA plans may operate, such as education.

an intervening third party, then all ERISA plan-owned or operated hospitals, clinics and other health care entities will be immune from assessments similar to the HFA.[2] Such a conclusion also necessarily would immunize hospitals and other health care entities operated by ERISA plans from traditional exercises of the police power applicable to those entities, since such laws would have an "immediate impact on the operations of" the plan. *Id.* It would thus follow from the Second Circuit's decision that an ERISA plan would be free to operate a hospital, clinic or home care agency without regard to state medical waste and staffing rules since they too would have a "direct" and "immediate" impact. The plan would be equally free to establish a hospital in total disregard of state licensure laws. This immunity from state regulation will encourage plans to discontinue providing health care to their members through the system of community-based providers, and to establish their own facilities.

The impact of the Second Circuit decision is even more far reaching, given the explosion in the 1990's of integrated delivery systems, generally referred to as health care networks.[3] This phenomenon is an outgrowth of the competitive pressures caused by managed care, which followed from the growth of health maintenance organiza-

[2] At lease 19 states have enacted some form of health care provider tax. *See* Brief for *Amicus Curiae* for the States of Connecticut, *et al.* at 8, n.2.

[3] A network is a term that covers a broad range of relationships, from joint purchasing to the provision of a full range of health care services, oftentimes including the assumption of risk by an entity that enrolls participants. Organizationl arrangements may be among similar providers (*e.g.*, two or more hospitals linked to provide services)—referred to as horizontal integration—or they may involve various levels of providers (*e.g.*, hospital/physician group/nursing home)—commonly referred to as vertical integration. These networks may also involve the participation, through contractual or common ownership arrangements, of payers, such as self-insured employers or managed care plans.

tions. ERISA funds are not outsiders looking in on this health care revolution. They are integrally involved in the formation of networks, as they have the same cost pressures and other considerations all payers and providers have.

In 1994, the Hospital Trustees of New York State reported that 45% of acute care facilities surveyed nationwide had formed an integrated delivery system in the preceding twelve months, and that another 25% indicated that they would enter into some form of integrated care in the coming six months.[4] In New York City, hospital system and network formation has been so great that another 1994 survey conducted by the Greater New York Hospital Association reported that 82% of respondents were already in at least one network or system, more than 1 in 3 reported being in two or more networks, and almost half were part of a system in which they had equity or ownership in a managed care organization.[5] While there are many reasons for the formation of networks, "the most pressing is the clear indication that the healthcare reform discussions will result in some financing system that will reward the efficiencies suggested by streamlining and integrating care through networks."[6]

The test for ERISA preemption, as applied by the Second Circuit, poses major problems as ERISA funds develop or participate in these networks.[7] The *NYSA-*

[4] HOSPITAL TRUSTEES OF NEW YORK STATE, AN INTRODUCTION TO HEALTH CARE NETWORKS i (1994).

[5] *Id.* at 6.

[6] *Id.* at i.

[7] The National Academy for State Health Policy has already expressed concern regarding the ability of states to exercise their traditional police powers over health care provider networks under ERISA. *See* PATRICIA A. BUTLER & ELIZABETH MITCHELL, HEALTH CARE PROVIDER NETWORKS: REGULATORY ISSUES FOR STATE POLICY MATTERS (National Academy for State Health Policy, Feb. 1996). The National Academy report specifically questions whether ERISA

ILA decision of the Second Circuit, if allowed to stand, will immunize entire health networks from state regulation, and in ever-increasing numbers. While the *NYSA-ILA* case involves one fund-operated hospital's immunity from a generally-applicable assessment, there is no logical difference between immunizing that one hospital and immunizing an entire health care system owned, operated or participated in by NYSA-ILA or any other fund. And, as discussed above, there is no logical difference between the regulation of quality of care or work standards in a hospital and the regulation of hospital costs. It does not take much imagination to realize that it is this broader immunity that Respondent seeks to gain from this preemption challenge, and not just the dollars it pays on this assessment.

II. THE SECOND CIRCUIT'S DECISION DIRECTLY CONFLICTS WITH THE *TRAVELERS* DECISION OF THIS COURT.

The Second Circuit's decision is incompatible with this Court's decision in *Travelers,* which is why it now presents the ramifications discussed above. It reduces *Travelers* to a narrow and inconsequential holding by finding significance only insofar as *Travelers* upholds laws that have mere indirect effects upon the assets of a plan. In doing so, the Second Circuit ignores the fundamental principles established by this Court in *Travelers; i.e.,* that Congress could not have intended ERISA to displace traditional state health care regulation, that preemption must be evaluated in light of ERISA's purpose to promote national uniformity, and that the test is not whether the state law increases costs to a plan, but whether it mandates plan decisions. That the Second Circuit would so narrowly read *Travelers* as to make it irrelevant to the rapidly evolving health care scene calls

precludes a state from regulating a provider network to the extent it enters into an arrangement with self-insured ERISA plans.

for this Court's intervention to reaffirm the principles of *Travelers.*

Referencing its earlier decision that was vacated and remanded by this Court, the Second Circuit observed that the HFA increases costs and "depletes those assets [of the Respondent ERISA plan] earmarked for the provision of health care benefits . . . ." *NYSA-ILA Medical & Clinical Servs. Fund,* 74 F.3d at 30. But, recognizing that *Travelers* rejected the notion that increased costs, by themselves, justify preemption, the Second Circuit then narrowed its rationale by distinguishing *Travelers* based on the HFA's "direct" impact upon Respondent ERISA plan. That is a futile effort to distinguish *Travelers.*

First, the Circuit Court's distinction between laws that "directly" impact upon ERISA plans from those that "indirectly" impact such plans makes little sense because it would rest ERISA preemption on whether or not there is a "middleman" between the state law and the ERISA plan.[8] But, as discussed above, if that were the test, ERISA plans would be free to operate hospitals and medical clinics immune from any state health care regulation, including licensure, medical waste, and staffing and

[8] The distinction between direct and indirect effects is one of difficult application, the line between the two often being very blurry. Indeed, it appears that the Second Circuit misapplied its own test here since the HFA has only an indirect impact on the self-insured plan. Incorporated as not-for-profit corporations under special acts of the New York Legislature, the medical centers that claim to be exempt from the HFA are separate legal entities from Respondent self-insured plan that operates them. *See* Joint Appendix in the Record below, at 142-43. While there may be a close financial and operational relationship between the entities, the fact is that the HFA was imposed on the receipts of a separate hospital corporation established by the fund, and not on the ERISA fund itself. This direct/indirect test will become even more difficult to apply as vendors and employers become partners, and previously autonomous organizations consolidate into complex networks. *See* James C. Robinson, *Health Care Purchasing and Market Changes in California,* HEALTH AFFAIRS, Winter 1995, at 117-30.

quality assurance rules, "unsettling result[s]" that would impute a congressional intent that never existed. *Travelers*, 115 S. Ct. at 1681. In fact, the distinction would allow ERISA plans to venture into a variety of new areas by providing direct services without regard to traditional state regulation. For instance, ERISA scholarship plans would be able to operate schools free of state education laws and ERISA day care plans would be able to operate day care centers free of all state day care rules.

Second, the Second Circuit's distinction would elevate form over substance by looking at a state law's source, instead of the character of its impact. Even though there is little substantive economic difference between a "payer" assessment and an identical "provider" assessment (the payer assessment is imposed on monies paid to, and the provider assessment is imposed on the same monies received by, health care providers), the Second Circuit would treat them differently under ERISA.

Third, a direct/indirect distinction fails to fit within ERISA's framework. Since, by their very nature, only self-insured plans (as opposed to other ERISA plans) can operate as health care providers, they are the only type of ERISA entity that presumably can be "directly" impacted by state health care laws. Hence, under the Second Circuit's distinction, ERISA would preempt a state health law insofar as it impacts self-insured ERISA plans, but not insofar as that law impacts commercially-insured and other types of ERISA plans. Yet, with one isolated exception described in ERISA Section 514(b)(2) (codified at 29 U.S.C. § 1144(b)(2) (1994)), ERISA's preemption provision does not differentiate self-insured plans from other types of ERISA plans. As for that sole exception, ERISA Section 514(b)(2)(A) (codified at 29 U.S.C. § 1144(b)(2)(A) (1994)), which is known as the "savings" clause, preserves certain enumerated state laws, including state insurance laws, that otherwise "relate to" ERISA plans. The so-called "deemer" clause

described in Section 514(b)(2)(B) (codified at 29 U.S.C. § 1144(b)(2)(B) (1994)), however, provides that for purposes of the savings clause, self-insured plans are not to be deemed as insurers and therefore are exempt from state laws purporting to regulate insurance. The Second Circuit's direct/indirect distinction thus effectively stretches the deemer clause concept beyond its limits by exempting self-insured ERISA plans from any law—and not merely an insurance law—that "directly" impacts such plans.

Moreover, the Second Circuit's distinction loses sight of this Court's decision in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988). In *Mackey*, this Court ruled that ERISA did not preempt a Georgia state garnishment law even though the law applied directly to ERISA welfare plans. In fact, it was of no consequence to this Court that in garnishing a plan under the state law, "plan trustees [were] served with a garnishment summons, [became] parties to a suit, and . . . respond[ed] and deposit[ed] the demanded funds due the beneficiary-debtor." *Id.* at 831.[9]

By distinguishing *Travelers* at the outset, the Second Circuit also failed to pay attention to this Court's defining approach toward ERISA preemption issues. In *Travelers*, this Court commenced its analysis with the well-established presumption against preemption, a canon designed to preserve the regulatory authority of the states absent clear congressional intent to supersede such authority. *Travelers*, 115 S. Ct. at 1676. Then, noting that ERISA's "relate to" language was not "helpful" in ascer-

[9] For that matter, this Court also has found preemption where a state law only indirectly affects ERISA plans. *See, e.g., Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) ("a state law may 'relate to' a benefit plan . . . even if the law is not specifically designed to affect such plans, or the effect is only indirect"); *c.f. Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981) ("It is of no moment that New Jersey intrudes indirectly, through a workers' compensation law, rather than directly . . . .").

taining Congress's intent, the Court turned to ERISA's statutory purposes and legislative history as a guide to the scope of ERISA's preemption provision. *Id.* at 1677. To that end, the Court concluded that the "basic thrust of the pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 1677-78. The Court then cited some of its prior ERISA pre-emption cases to illustrate the types of laws that frustrate ERISA's uniformity objective, including laws that mandate a level of plan benefit or the type of plan structure. *Id.* at 1678 (citing *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983) (holding that New York laws that prohibited ERISA plans from discriminating on the basis of pregnancy and required them to pay certain benefits "related to" ERISA plans); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (holding that ERISA preempted a state anti-subrogation law that prohibited ERISA health plans from being structured to require reimbursement in the event of recovery from a third party)).

According to this Court, however:

> nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a local concern.

Id. at 1680 (citations omitted). The Court explained that while the surcharges and other health care regulation may increase the cost of certain benefits, that economic effect, by itself, is insufficient to justify preemption.[10] In contrast to laws that contain substantive benefit

[10] That rule was recently followed in *Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied*, 116 S. Ct. 1266 (1996), where the Eighth Circuit rejected an ERISA challenge to a two percent Minnesota provider tax. Like the HFA, the Minnesota provider tax was imposed on the gross revenue of hospitals and other health care providers. Minnesota law, however, goes one step further than the HFA by expressly authorizing health care providers to pass the costs of the tax "directly" onto third-party payers, including self-insured ERISA plans. *Id.* at 1098, quoting MINN. STAT. § 295.582 (Supp. 1993).

mandates, generally applicable health laws that merely increase costs do not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself . . . ." *Id.* at 1679.

Here, the Second Circuit did not seek to ascertain Congress's intent, the "ultimate touchstone" in every preemption question. *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)). The Circuit Court never attempted to determine how preemption of the HFA would further ERISA's objective in maintaining nationally uniform rules for the administration of employee benefit plans. Nor did the court cite any other statutory, legislative or policy reason supporting its preemption finding. Rather, the Second Circuit summarily affirmed its prior preemption decision—with its original infirmities[11]—based on its newly-created direct/indirect distinction. In short, the Second Circuit decided this case in spite of, and not in light of, *Travelers*.

[11] The Second Circuit preemption holding appears to have been swayed by the fact that the HFA is a health law, a fatal flaw in the Circuit Court's reasoning. In its initial opinion, the Second Circuit accepted the principle that ERISA does not preempt generally-applicable laws insofar as they affect ERISA plans, including laws that "directly" apply to such plans such as sales, utility and gasoline taxes. The Circuit Court, however, found that health laws are not generally applicable because they do "not apply broadly to every sector of society" and are "bound to affect" ERISA plans particularly. *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 27 F.3d 823, 827 (2d Cir. 1994), *vacated and remanded*, 115 S. Ct. 1819 (1995), *ratified upon reconsideration*, 74 F.3d 28 (2d Cir. 1996). The problem is that this notion not only is irreconcilable with *Travelers*, it was expressly rejected when this Court observed that nothing in ERISA indicates that it "displace[s] general health care regulation." *Travelers*, 115 S. Ct. at 1680.

CONCLUSION

It is respectfully requested that this Court grant the petition of Barbara A. DeBuono, M.D., Karen Schimke and Deputy Director for a writ of certiorari.

Respectfully submitted,

MARK THOMAS
HEALTHCARE ASSOCIATION
OF NEW YORK STATE
74 North Pearl Street
Albany, NY 12207

FREDRIC J. ENTIN
AMERICAN HOSPITAL
ASSOCIATION
One North Franklin
Chicago, Illinois 60606

JEFFREY J. SHERRIN *
PHILIP ROSENBERG
SHERRIN & GLASEL
74 North Pearl Street
Albany, New York 12207
(518) 465-1275
Counsel for Amici Curiae

Dated: Albany, New York
April 30, 1996

* *Counsel of Record*

(4)

No. 95-1594

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IN THE

Supreme Court of the United States

October Term, 1995

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

against

NYSA-ILA MEDICAL AND CLINICAL LEGAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS and PETER VICKERS,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF AMICUS CURIAE FOR THE STATES OF CONNECTICUT, et al. IN SUPPORT OF PETITIONERS

RICHARD BLUMENTHAL
Attorney General of Connecticut
Counsel of Record

PHYLLIS E. HYMAN
Assistant Attorney General

55 Elm Street
Hartford, CT 06141-0120
(203) 566-2026

Of Counsel:
DAN SCHWEITZER
DANIEL SMIRLOCK

National Association of
Attorneys General
444 North Capitol Street
Suite 339
Washington, D.C. 20001

(Additional Counsel Listed on Inside Cover)

Printed on Recycled Paper

2900

GRANT WOODS
Attorney General
State of Arizona
1275 West Washington
Phoenix, AZ 85007-2997

WINSTON BRYANT
Attorney General
State of Arkansas
200 Tower Building
323 Center Street
Little Rock, AR 72201-2610

MARGERY S. BRONSTER
Attorney General
State of Hawaii
Hale Auhau
425 Queen Street
Honolulu, HI 96813

ANDREW KETTERER
Attorney General
State of Maine
6 State House Station
Augusta, ME 04333

J. JOSEPH CURRAN, JR.
Attorney General
State of Maryland
200 Saint Paul Place
Baltimore, MD 21202-2021

SCOTT HARSHBARGER
Attorney General
Commonwealth of Massachusetts
One Ashburton Place
Boston, MA 02108

MIKE MOORE
Attorney General
State of Mississippi
P.O. Box 220
Jackson, MS 39205-0270

JOSEPH P. MAZUREK
Attorney General
State of Montana
Justice Building
P.O. Box 201401
Helena, MT 59620-1401

FRANKIE SUE DEL PAPA
Attorney General
State of Nevada
Old Supreme Court Building
198 South Carson
Carson City, NV 89710

JEFFREY R. HOWARD
Attorney General
State of New Hampshire
33 Capitol Street
Concord, NH 03301

DEBORAH T. PORITZ
Attorney General
State of New Jersey
Richard J. Hughes Justice Complex
25 Market Street
Trenton, NJ 08625

W.A. DREW EDMONDSON
Attorney General
State of Oklahoma
State Capitol
2300 North Lincoln Boulevard
Suite 112
Oklahoma, City, OK 73105-4893

THOMAS W. CORBETT, JR.
Attorney General
Commonwealth of Pennsylvania
15th Floor, Strawberry Square
Harrisburg, PA 17120

JEFFREY B. PINE
Attorney General
State of Rhode Island
150 South Main Street
Providence, RI 02903

(Names of Counsel Continued)

DAN MORALES
Attorney General
State of Texas
P.O. Box 12548
Austin, TX 78711-2548

JEFFREY L. AMESTOY
Attorney General
State of Vermont
109 State Street
Montpelier, VT 05609-1001

JAMES S. GILMORE, III
Attorney General
State of Virginia
900 East Main Street
Richmond, VA 23219

DARREL V. MCGRAW, JR.
Attorney General
State of West Virginia
State Capitol, Room E-26
Charleston, WV 25305

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No. 95-1594

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BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF AMICUS CURIAE FOR THE STATES OF CONNECTICUT, et al. IN SUPPORT OF PETITIONERS

The amici curiae states, through their attorneys general, respectfully submit this brief in support of New York's petition for certiorari.

STATEMENT OF INTEREST

Review of the Second Circuit's decision is of critical and immediate importance to all states, particularly those in which ERISA plans own health care facilities. Under the Second Circuit's decision, *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 74 F.3d 28 (2d Cir. 1996), state regulation of such facilities will be severely curtailed, if not eliminated entirely. Even states in which ERISA plans do not currently own health care facilities will be significantly affected: if the decision below remains the law, it is only a matter of time before health care facilities reorganize themselves as plan-owned so that they, too, can evade state public health regulation. The amici states urge this Court to grant certiorari and reverse the Second Circuit's decision.

The Second Circuit held that New York's generally applicable "Health Facility Assessment," N.Y. Pub. Health Law § 2807-d (McKinney 1993 & Supp. 1995), consisting of 0.6% of a medical center's gross receipts, is preempted by ERISA[1] solely because it falls, in the present case, directly on an ERISA plan -- that is, there is "no third party between the plan and the tax." 74 F.3d at 30. In the Second Circuit's view, the supposedly "direct" impact of the assessment on plan-owned facilities distinguishes this case from *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S.Ct.

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[1]ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...." 29 U.S.C. § 1144(a) (1988).

1671 (1995) ("*Travelers*"), in which this Court upheld against an ERISA preemption challenge a statutorily-mandated increase in charges for health care services that had an "indirect" effect on plan costs by virtue of the resulting increase in the cost of purchasing health care services.

This distinction is legally unsound and presents serious obstacles to the states in the exercise of their traditional authority over health care. States are responsible for the regulation of all health care facilities, regardless of their form of ownership. If the decision below is left standing, states will be precluded from exercising their customary authority in the health care field over plan-owned health care facilities, because all regulation has inherent costs that will be imposed "directly" on the plan-owned facilities. There is, moreover, no question that, if *NYSA-ILA* is the law, hospitals and other health care facilities will find a way to reorganize themselves as plan-owned facilities in order to evade state regulation. In states like Connecticut, where all hospitals and many other health care facilities are owned by non-profit entities, such institutions will probably be driven out of business. In addition, as discussed *infra*, if ERISA-owned hospitals are exempt from state health care taxes and other generally applicable state taxes, many states are at risk of losing millions of dollars in federal Medicaid funding, which by statute depends on the uniform application of state tax laws to all health care facilities in a given class. If health care facilities owned by ERISA plans are exempt from state taxation, state taxes may not satisfy federal statutory requirements for receiving matching federal funds.

States are responsible for protecting the health and safety of *all* their residents and regulating *all* the health care facilities within their jurisdictions. Their power to regulate public health and safety through laws of general application must not be made to depend on the organizational choices of ERISA plans. Under *NYSA-ILA*, the health care services obtained by participants in

an ERISA plan that elects to provide its services directly will be entirely unregulated by state law. Rather than the states determining how much regulation is necessary to protect the public's health and safety, ERISA plans that operate their own facilities will be dictating to both the states and plan participants the extent to which the state may regulate. ERISA plans must not be afforded an exemption from generally applicable laws. Preemption of any state law that taxes or regulates plan-operated facilities would cripple the states' power to regulate in the area of public health, compromise their ability to participate in Medicaid, and be contrary to effective, rational public policy.

SUMMARY OF ARGUMENT

This Court should grant certiorari in order to clarify as soon as possible whether plan-operated health facilities are exempt from general state regulation. Because the Second Circuit's decision is based not on the nature of the particular assessment at issue but on the supposedly "direct" effect of that assessment on ERISA plans, the holding below casts in doubt virtually any aspect of state law that increases a plan-run facility's costs. The states need this Court to clarify whether they are at risk of losing their traditional power to regulate in the area of public health and safety whenever an ERISA plan directly operates a health care provider. In addition, the states must learn as soon as possible whether they will remain eligible for millions of dollars of matching federal Medicaid funds, which by federal statute are contingent upon states' health care provider taxes being applicable to all providers within a specific class. If ERISA-owned facilities are exempt from otherwise applicable state health care provider taxes, the states' entitlement to matching Medicaid funds is in jeopardy. Congress, too, should learn without delay whether this Court believes that the ERISA preemption clause was truly intended to exempt plan-owned facilities from state

regulation. This Court should take the opportunity to issue an authoritative holding to which Congress may enact a legislative response.

The Second Circuit's decision is in conflict with this Court's decisions in *Travelers* and in *Mackey v. Lanier Collection Agency & Service*, 486 U.S. 825 (1988). In *Travelers*, this Court upheld, against an ERISA preemption challenge, a New York statute imposing surcharges on the hospital bills of all patients with health care coverage from commercial insurers. These charges were presumably passed through to ERISA plans that purchased insurance for their participants. The Court recognized that Congress did not intend that ERISA preempt generally applicable laws in areas of traditional state regulation, and held that "a law operating as an indirect source of merely economic influence" on the decisions of ERISA plans is not preempted. 115 S.Ct. at 1680. In the Second Circuit's view, the supposedly "direct" effect of New York's Health Facility Assessment on a plan-run facility justified a result different from that reached in *Travelers*. But nothing in *Travelers* indicates that the "directness" of a generally applicable state assessment is, without more, a basis for preemption. By contrast, everything in the decision demonstrates that in this Court's view Congress did not intend that general state laws be preempted simply because they increase the costs of an ERISA plan. *Mackey*, on which *Travelers* relied extensively, likewise makes clear, in direct conflict with the decision below, that a generally applicable state statute is not preempted by ERISA, even when it has the effect of directly depleting plan assets.

The Second Circuit's decision also conflicts with the decision in *Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied*, 116 S.Ct. 1266 (1996), and with the reasoning of the Sixth and Ninth Circuits in decisions upholding generally applicable tax statutes against ERISA preemption challenges. In *Boyle*, the Eighth Circuit upheld a Minnesota statute imposing a 2% tax on

the gross revenues of health care providers, authorizing providers to transfer the cost of the tax to third party contracts for the purchase of health care, and requiring all third party payers to pay the transferred tax. The economic effect of the Minnesota tax is exactly that of the New York assessment, yet the Eighth and Second Circuits reached opposite results. Similarly, the Sixth and Ninth Circuits have upheld neutral, generally applicable taxes that deplete plan assets or deprive plan participants of benefits. *See Retirement Fund Trust of the Plumbing v. Franchise Tax Board*, 909 F.2d 1266 (9th Cir. 1990); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987). The Second Circuit, in its decision in the present case, preempted a similarly neutral and generally applicable state law solely because its economic effect on an ERISA plan was direct. This Court should grant certiorari to resolve this conflict between the circuits.

REASONS FOR GRANTING REVIEW

I. THE DECISION BELOW SIGNIFICANTLY IMPAIRS THE STATES' ABILITY TO REGULATE HEALTH CARE.

The decision below has the potential to change the entire landscape of health care regulation. Plan-operated health care facilities are increasingly common. *See, e.g.*, Robert Kazel, *Onsite Clinic Expected to Cut Delta Comp Tab*, Business Insurance, January 29, 1996, at 6 (Delta Air Lines builds "occupational health clinic" for its employees); Louise Kertesz, *Employers, Insurers Center Attention on Primary Care*, Modern Healthcare, June 19, 1995, at 136 (Noting "the trend toward employer-sponsored clinics"); Jonathan W. Harris, *On-Site Health Clinics*, The Self-Insurer, January, 1995, at 6 ("employer-sponsored care systems have gained in popularity as

employers continue their attempts to control health care costs"); Deborah S. Cowans, *Interest in Employer-Sponsored Clinics Grows*, Business Insurance, February 21, 1994 at 3. The advent of new forms of health care delivery, in which employers contract directly and sometimes exclusively with health care providers, renders the issue of ERISA preemption even more critical to resolve. *See, e.g.,* Robert Pear, *Doctors May Get Leeway to Rival Large Companies,* N.Y. Times, April 8, 1996, at A1; Laura Johannes, *Doctor Networks Campaign to Offer Health Insurance*, Wall St. J., Jan. 8, 1996, at B1. If the Second Circuit's decision goes unreviewed, there is no doubt that ERISA plans will do everything in their power to restructure themselves to avoid the imposition of assessments and other forms of state regulation, thereby hampering the states' ability to ensure the health and safety of their residents who use the services offered by these plans.

The decision below exempts plan-run facilities from a state assessment that all other health care providers must pay. The basis of the decision is not the nature of the New York Health Facilities Assessment but the directness of its impact. There is thus no principled way to limit its application. All state laws and regulations apply "directly" to any ERISA plan that owns a facility. Not only provider taxes, but also property taxes, payroll taxes and sales taxes, all of which increase the costs of operating a facility, are fair game for preemption when plans run health care facilities. Similarly, if plans operate other types of facilities that are subject to state taxation or regulation, such as day care centers, legal clinics or nursing homes, such state laws would also be preempted under the analysis of the court below.

Health care provider taxes are a common means by which states raise revenue.[2] Federal Medicaid law envisions that states

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[2]*See* Ala. Code § 40-26B-21 (1995) (imposing "providers of medical services privilege tax" on nursing facilities); Conn. Gen. Stat. § 12-263(b) (1994) (tax of 11% on "hospital gross earnings of each hospital"); Fla. Stat. § 395.7015 (1995) (imposing 1.5% assessment on annual net operating revenues of certain "health care entities"); Haw. Rev. Stat. § 346E-2 (1995) (taxes of 6% and 4% imposed on "nursing facility income" and "hospital income" respectively); Ill. Comp. Stat. Ann. § 305 ILCS 5/5A-2 (Michie 1996) (assessment of 1.88% of "adjusted gross hospital revenue" of "each hospital provider"); Ky. Rev. Stat. Ann. § 142.303 (Michie 1995)(2.5% tax on gross revenues of providers "for the provision of hospital services"); Me. Rev. Stat. tit. 22, § 391 (1995) (assessment of .15% of hospital's "gross patient service revenues"); Mass. Ann. Laws ch. 118F, § 15 (Law. Co-op. 1995) (hospital assessments calculated by State Department of Medical Security); Minn. Stat. § 295.52 (1995) (2% tax on gross revenues of hospitals and health care providers); Miss. Code Ann. § 43-13-145 (1995) (assessment on nursing homes of two dollars per bed per day); Mo. Rev. Stat. § 208.453 (1994) (hospitals pay "federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care"); Mont. Code Ann. § 15-60-102 (1995) ($ 2.80 "utilization fee" paid by each "nursing facility" for "each bed day in the facility"); N.H. Rev. Stat. Ann. § 84-A:2 (1994) (tax "at a rate to be established by the legislature each biennium upon the gross patient services revenue of every hospital"); R.I. Gen. Laws § 44-51-3 (1995) (assessment of 3.75% on "gross patient revenue received by every nursing facility"); S.C. Code Ann. § 12-23-810 (1993) (hospital tax based on total expenditures of each hospital as a percentage of total hospital expenditures state-wide); Tenn. Code Ann. § 68-11-216 (1995) (annual nursing home tax of $2,600 per licensed bed per year); Utah Code Ann. § 26-36-105 (1995) (Medicaid Hospital Provider Temporary Assessment imposed on hospitals' "audited gross inpatient revenues"); W.Va. Code Ann. §§ 11-27-9, 11-27-15 (Michie 1995) (health care provider tax of 2.5% of

(continued...)

will impose health care related taxes on various classes of health care provider and then obtain matching federal payments. *See* 42 U.S.C. § 1396b(w)(3)(A)(i) (1995). In order to qualify for matching funds, a state tax must be imposed uniformly on all services within a particular class of provider. *Id.* at 1396b(w)(3) (1995). Under *NYSA-ILA*, however, health care facilities operated by ERISA plans will be exempt from "direct" taxation. If states are prevented from enforcing their health care taxes uniformly, they may not qualify for federal payment under the Medicaid program. Indeed, it is difficult to see how the Second Circuit could have arrived at its holding had it squarely confronted this conflict between its view of ERISA preemption and the federal Medicaid statute, for its decision would have violated the principle of statutory construction that a court must read potentially conflicting statutes "to give effect to each if [it] can do so while preserving their sense and purpose." *Watt v. Alaska*, 451 U.S. 259, 267 (1981).

In addition to health care related taxes, other state laws and regulations that govern health care providers and ensure the health and safety of patients and the general public will, under the Second Circuit's holding, be unenforceable against health care facilities owned by ERISA plans because they too will have a direct impact on such facilities. State licensing laws and the regulations that implement them require health care facilities to meet a wide variety of minimum standards in areas such as

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[2](...continued)
gross receipts on providers of "inpatient hospital services" and "outpatient hospital services"); Wis. Stat. § 50.14 (1994) (assessment on "occupied, licensed beds" of nursing home facilities). In all but four of these states, the provider taxes are structured to enable the states to obtain matching federal funds. *See* Department of Health and Human Services Reports of Provider Related Donations and Health Care Related Taxes Received for Quarters Ending September 30, 1995 and June 30, 1995.

staff-patient ratios and infection-control practices. *See, e.g.*, Ariz. Rev. Stat. Ann. §§ 36-422--36-425 (1993 & Supp. 1995); Conn. Gen. Stat. §§ 19a-490--496 (1994); Ill. Comp. Stat. Ann. § 210 ILCS 85/1--85/16 (Michie 1996) (Hospital Licensing Act); N.J. Stat. Ann. § 26:2H-12 (1994). States also impose strict standards concerning the disposal of medical waste to protect both patients and the general public. *See, e.g.*, Cal. Health & Safety Code §§ 117600--118360 (Deering 1995); Fla. Stat. § 381.0098 (1995); Okla. Stat. Ann. tit. 27A, § 2-10-308 (West Supp. 1996); R.I. Gen. Laws § 23-19.12-1--19 (1995).

Similarly, states invariably regulate the facilities in which child day care is offered and demand that the people who offer such care meet certain qualifications. *See, e.g.*, Conn. Gen. Stat. § 19a-80 (1995) (requiring licensing of day care centers); Conn. Agencies Regs. §§ 19a-79-1a--12 (1993) (setting forth personnel and facility requirements for license); N.Y. Soc. Serv. Law § 390 (McKinney 1995) (authorizing Commissioner of Social Services to promulgate rules governing licensure of day care facilities); N.Y. Comp. Codes R. & Regs. tit. 18, §§ 418.1 -- 418.20 (1995) (setting forth requirements). And states closely regulate the practice of law. *See, e.g.*, Conn. Gen. Stat. §§ 51-80--88 (1995) (setting forth requirements for practitioners); N.Y. Jud. Law § 90 (McKinney 1995) (authorizing state appellate courts to establish rules of practice); N.Y. Comp. Codes R. & Regs. tit. 22, Parts 603, 691, 806, 1022 (1995) (regulations governing practice). Under the Second Circuit's holding, however, whenever an ERISA plan operates a day care center or a legal clinic, any regulations that increase the plan's costs affect it directly and are therefore preempted.

If it is within ERISA plans' power to avoid the costs imposed by ordinary state regulation, they will surely undertake whatever reorganization enables them to do so. States will be powerless to regulate in areas in which they have traditionally had full regulatory authority--a result that Congress, in enacting the

ERISA preemption statute, cannot possibly have contemplated. Congress's intent is the "ultimate touchstone" of ERISA preemption. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 [1978]). Congress should have the opportunity to understand fully the ramifications of the present case and to consider whether it is necessary to amend ERISA, as it did in 1982 to override a 1981 decision of this Court preempting Hawaii law. *See Retirement Fund Trust of the Plumbing*, 909 F.2d at 1277. In a matter of such immediate consequence, this Court should not await further conflicts and confusion, but should act at once to clarify the law.

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S DECISIONS IN *TRAVELERS* AND *MACKEY*.

When this Court vacated the Second Circuit's original decision in the present case and remanded the case for further consideration in light of *Travelers*, *see* 115 S.Ct. 1819 (1995), it confirmed what *Mackey* established: A generally applicable state statute that produces an economic effect on ERISA plans is not, for that reason alone, preempted by ERISA. The Second Circuit, misapprehending *Travelers*, believed that the "directness" of such an effect distinguished New York's Health Facility Assessment from the surcharges at issue in *Travelers*. This conclusion, however, rests on a misreading of *Travelers*, which does not make the directness of a state law's impact dispositive for ERISA preemption purposes. The resulting conflict between *Travelers* and the present case warrants review by this Court.

At issue in *Travelers* was a New York statute requiring hospitals to collect surcharges on the hospital bills of patients with health care coverage from a commercial insurer, but not on the bills of patients insured by Blue Cross/Blue Shield. This

Court reversed a decision of the Second Circuit, which had held that this statute was preempted by ERISA. "The basic thrust of the [ERISA] pre-emption clause," the unanimous Court noted, "was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." 115 S.Ct. at 1677-78. This understanding of the purpose of ERISA preemption meant that the statute at issue in *Travelers* was not preempted. Because this statute affected only "choices made by insurance buyers, including ERISA plans," it did not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself" or "preclude uniform administrative practice or the provision of a uniform interstate benefit package." *Id.* at 1679.

The Court emphasized that generally applicable laws in traditional areas of state regulation are not preempted simply because of their economic effect on ERISA plans. Thus, for example, "[q]uality control and workplace regulation" in hospitals have the effect of increasing health care costs and thus insurance costs, but do not amount to the " 'conflicting directives' from which Congress meant to insulate ERISA plans." *Id.* at 1679-80. The Court found this conclusion "confirmed by [its] decision" in *Mackey*, in which a general state garnishment statute, applied to a plan participant's benefits in the hands of an ERISA plan, "impose[d] administrative costs and burdens upon benefit plans" but was not preempted. *Travelers*, 115 S.Ct. 1680. "Any conclusion other than the one we draw," the Court observed, "would bar any state regulation of hospital costs," which, as "interference with the hospital services market, would fall on a theory that all laws with economic effects on ERISA plans are pre-empted." The surcharges at issue in *Travelers* affected only "the relative prices of insurance policies," and were thus "no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate," *id.* at 1683; *see also id.* at

1680 (Nothing in language or legislative history of ERISA "indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern").

The decision in *Travelers* leaves no room for ERISA preemption of a generally applicable state assessment on the gross receipts of health care providers, even when a provider is operated directly by an ERISA plan. The Court emphasized that traditional areas of state regulation--including generally applicable state charges that increase the costs of doing business for hospitals and/or insurers--are not preempted simply because of their economic effect on ERISA plans.

Similarly, the Court stressed that a statute with an economic effect on ERISA plans is not preempted unless it has a coercive or preclusive effect on plans' administrative practices, and distinguished carefully between a state statute that merely "affect[s] insurance prices and plan costs" and one that "impose[s] a substantive mandate" on plans. *Id.* at 1681. This reasoning can be and should have been applied to the present case, in which the Health Facilities Assessment, like the surcharge at issue in *Travelers,* does not bind plan administrators to a particular choice or method of operation, but instead merely operates in an area of traditional and general state regulation to increase plans' costs of doing business.

Indeed, if the plan in the present case had operated in the more usual fashion and reimbursed outside health care providers for medical services provided to plan participants, the case would be identical to *Travelers* in every respect. It is only because NYSA-ILA has chosen to operate its own medical center that the factual circumstances of the cases differ at all. But nothing in ERISA or in *Travelers* supports the conclusion that a generally applicable state statute that has the effect of increasing costs to ERISA plans is somehow invalid when, and only when, an ERISA plan operates the entity subject to state

regulation. The Second Circuit itself, in two post-*Travelers* decisions, rejected such an approach, observing that "in the wake of *Travelers* (and the Court's decision to vacate *NYSA-ILA)*, we question whether we should continue to distinguish between laws that directly deplete ERISA plans' assets and laws that only indirectly do so." *New England Health Care Employees Union, District 1199 v. Mount Sinai Hospital*, 65 F.3d 1024, 1032 (2d Cir. 1995); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 63 F.3d 90, 94 (2d Cir. 1995) (holding that surcharges apply to self-insured plans as well as those that purchase insurance).

Unfortunately, the Second Circuit did not take its own counsel in the present case, and thus produced the conflict with *Travelers* that now must be resolved. In *Travelers*, this Court found the notion that ERISA preempts all state laws affecting "the hospital services market" to be "unsettling" and "startling." 115 S.Ct. at 1681. The same adjectives can be applied to the principle that an unquestionably valid state tax on health care providers that would otherwise be passed through to ERISA plans suddenly becomes invalid when it is imposed "directly" on a plan-run facility. It is in order to correct this baseless conclusion that this Court should grant certiorari.

The decision below likewise conflicts with *Mackey*, on which the *Travelers* Court extensively relied. In *Mackey*, the Court upheld a state's general garnishment law that applied directly to the assets of an ERISA plan and imposed substantial administrative costs on the plan. This Court concluded that "Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans, *even when the mechanisms prevent plan participants from receiving their benefits.*" 486 U.S. at 831-32 (emphasis added). In *Mackey*, as in the present case, a generally applicable state law directly depleted plan assets that would otherwise have been available

for the use of participants.[3] Like *Travelers*, it cannot be squared with the decision below.

A different aspect of the holding in *Mackey* further establishes the need for this Court's review of the decision below. In concluding that a state statute specifically barring garnishment of plan benefits is preempted by ERISA, this Court observed that "any state law which singles out ERISA plans, by express reference, for special treatment is pre-empted," even when that special treatment is favorable to plans. 486 U.S. at 838. Thus, a state that wanted to exempt ERISA plans from generally applicable regulations could not do so directly. Yet according to the Second Circuit, New York has achieved precisely that result circuitously, by enacting a general statute applying "directly" to ERISA plans and thus automatically subject to preemption. This fundamental paradox, like the clear conflict between the holding below and those in *Travelers* and *Mackey*, indicates that this Court should grant review in order to align these otherwise incompatible decisions.

III. THE SECOND CIRCUIT'S DECISION CONFLICTS WITH THE DECISION OF THE EIGHTH CIRCUIT IN *BOYLE v. ANDERSON* AND WITH OTHER DECISIONS OF THE COURTS OF APPEALS.

The Second Circuit's decision cannot be reconciled with either the decision of the Eighth Circuit in *Boyle v. Anderson* or decisions of the Sixth and Ninth Circuits sustaining generally applicable state taxes against ERISA preemption challenges.

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[3] *Mackey* cannot be distinguished from the present case on the ground that it involved benefits payable to the particular plan participant whose assets were being garnisheed, for the Court noted that in the ERISA statute "no distinction is made between plan funds generally and those funds due a particular participant at a particular time." 486 U.S. at 835.

Boyle upheld, against an ERISA preemption challenge, a Minnesota statute imposing a 2% tax on the gross revenues of hospitals and other health care providers, Minn. Stat. § 295.52 (1995). If providers "transfer additional expenses generated by" the tax "on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer," then "[a]ll third-party purchasers of health care services...must pay the transferred expense in addition to any payments due under existing or future contracts" with a health care provider. *Id.* § 295.582 (1995). The workings on ERISA plans of Minnesota's provider tax are indistinguishable from the operation of New York's Health Facility Assessment on the present plaintiffs, yet the outcomes of *Boyle* and the present case are diametrically opposed. This Court should grant certiorari to resolve the conflict.

The plaintiffs in *Boyle* contended that ERISA preempted the "passthrough" to their plans of any portion of Minnesota's gross receipts tax. They asserted, among other things, that the tax amounted to a mandate directly regulating the terms of ERISA plans and that the economic impact of the tax on plans was itself sufficient for a finding of preemption. Relying both on the multi-factor analysis of ERISA preemption it had adopted in *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341 (8th Cir. 1991), and extensively on *Travelers*, the Eighth Circuit rejected plaintiffs' argument and concluded that none of the factors it considered weighed in favor of preemption. The generally applicable provider tax, which affected all health care providers and all third-party purchasers, did not "negat[e] a plan provision or relat[e] to other ERISA statutory provisions." *Boyle*, 68 F.3d at 1101-1102. It did not "result in any alteration in the authority of the primary ERISA entities" or "impose an administrative burden" on ERISA plans. *Id.* at 1102-1105. Rather, the passthrough did no more than "cause

the plans to pay a slightly increased fee for health care services already covered under the plans." *Id.* at 1103.

Nor was the economic impact of the tax sufficient to warrant preemption under ERISA. The court equated the required passthrough of the provider tax to third-party payers with the passthrough of other costs resulting from state laws that increase health care charges:"[H]ospitals pass through to third party payers such costs as those involved in disposal of hazardous chemicals, compliance with state OSHA standards; hospitals also pass on in their charges state unemployment compensation taxes, payroll taxes, and property taxes." *Id.* at 1107.

Like the 2% Minnesota provider tax, the New York assessment is imposed on the gross receipts of health care providers, albeit at a substantially lower rate. As with the Minnesota tax, health care providers in New York pass the cost of the assessment on to third-party purchasers of health care services, including ERISA plans. In both states, a statute establishes a generally applicable assessment and envisions that its costs will ultimately be borne by benefit plans and their contributors. The workings of the two taxes are indistinguishable, yet the Eighth and Second Circuits reached opposite results on the preemption question.

Respondents will undoubtedly contend that the difference between *Boyle* and the present case is that the present plaintiff is itself a health care provider and suffers a direct economic effect rather than the indirect effect felt by the plans in *Boyle*. As the Second Circuit conceived it, the ERISA plan in the present case *is* the medical center, and the costs of the provider tax (and all the other state-imposed costs of operating a health care facility enumerated by the Eighth Circuit) are not passed through but are direct. This distinction, however, even if it exists, is one without a difference.

First, it is not at all clear that the tax in *NYSA-ILA* is direct. The Second Circuit's holding overlooks the fact that the medical

centers responsible for paying the assessment and the ERISA plan on which the tax supposedly falls are separate entities. Each of the medical centers is separately incorporated as a New York not-for-profit corporation, to which the ERISA plan periodically transfers money to defray operating expenses. The assessment is imposed, not on the ERISA plan, but on the income of the separately incorporated medical centers. Thus, as in *Boyle*, the tax is imposed initially on the separate entity of the health care provider, and affects the ERISA plan only subsequently and indirectly.

Moreover, even if the Second Circuit's characterization of the assessment as falling "directly" on the ERISA plan is accepted, the present case conflicts with *Boyle* because in both cases the ERISA plans are legally obligated to pay the taxes. The plaintiffs in *Boyle* were required by statute to "pay the transferred expense" generated by the provider tax and passed through by providers "on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer." Minn. Stat. § 295.582. In the present case, because an ERISA plan chose to own a medical center, it was obligated to pay a general tax on health care providers. In both New York and Minnesota, the assets of ERISA plans will be "depleted" by virtue of a state assessment on the gross receipts of health care facilities. The only difference is that, in Minnesota, one additional level of billing must occur before the ERISA plan feels the effects of the tax. But this cannot be the basis of a principled or meaningful distinction between the cases. The conflict between *Boyle* and the case at bar is inescapable.

In addition to its direct conflict with *Boyle*, the Second Circuit's decision also conflicts with decisions of the Sixth and Ninth Circuits authorizing the application of general tax statutes directly upon the assets of ERISA plans. Thus, in *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987), the Sixth Circuit upheld a generally applicable 2% municipal tax on

income, even when that income was contributed by employees to their ERISA benefit plans. The tax did not violate ERISA because it constituted a traditional exercise of state authority and because it "affect[ed] Firestone employees in their capacity as employees, without regard to their status as participants in an ERISA plan." *Id.* at 555-56; *see also Thiokol Corp. v. Roberts*, 76 F.3d 751 (6th Cir. 1996) (following *Firestone* in upholding value-added tax on businesses even though tax included employers' payments to employees' benefit plans in calculating employee compensation for purposes of determining value added). New York's Health Facility Assessment operates in like fashion, incidentally affecting the ERISA plan only in its capacity as a health care facility and without regard to its status as an ERISA plan.

Similarly, in *Retirement Fund Trust of the Plumbing v. Franchise Tax Board*, 909 F.2d 1266 (9th Cir. 1990), the Ninth Circuit upheld against an ERISA preemption challenge certain general California tax levy and withholding procedures as applied to ERISA benefits owed to employees. The plaintiff trusts contended that such state procedures "dissipate" plan funds accumulated for plan participants' future use. *Id.* at 1282. Because, the Ninth Circuit said, the underlying tax at issue was valid, procedures to withhold or levy the tax were valid as well. *Id.* Expressly "agree[ing] with the Sixth Circuit's analysis" in *Firestone*, the Ninth Circuit noted that "Congress has preempted only state tax laws that 'relate to' ERISA plans," rather than all state tax laws that have an economic effect on plans but do not interfere with the calculation of benefits. *Id.* at 1281-82. New York's Health Facility Assessment is a similar tax.

The assessment at issue in the present case, like the taxes involved in *Boyle*, *Firestone*, and *Retirement Fund*, is entirely neutral, applying to all hospitals and health care providers in New York, not just to those operated by ERISA plans. Yet in the Second Circuit's view, a neutral, generally applicable

assessment that falls directly on the receipts of a plan-operated health facility merely by virtue of a plan's decision to structure benefits in a particular manner is preempted. There is no way to reconcile these decisions. Only this Court can definitively resolve the conflict between the circuits on this issue, and should grant New York's petition for certiorari in order to do so.

CONCLUSION

FOR THE FOREGOING REASONS, THE PETITION FOR CERTIORARI SHOULD BE GRANTED.

Dated:

Respectfully submitted,

RICHARD BLUMENTHAL
Attorney General of Connecticut
Counsel of Record

of Counsel:
DAN SCHWEITZER
DANIEL SMIRLOCK

National Association of
Attorneys General
444 North Capitol Street
Suite 339
Washington, DC 20001

PHYLLIS E. HYMAN
Assistant Attorney General

55 Elm Street
Hartford, Connecticut 06141-0120
(203) 566-2026

No. 95-1594

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

—against—

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOINT APPENDIX

BARBARA G. BILLET
Solicitor General
PETER H. SCHIFF
Deputy Solicitor General
DANIEL F. DE VITA
Assistant Attorney General
in Charge of Labor Bureau
M. PATRICIA SMITH*
Assistant Attorney General

DENNIS C. VACCO
Attorney General of the
State of New York
Attorney for Petitioners
120 Broadway
New York, New York 10271
(212) 416-8707

* *Counsel of Record*

(For Further Appearances See Reverse Side of Cover)

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Thomas W. Gleason
Ernest L. Mathews, Jr.*
GLEASON & MATHEWS, P.C.
26 Broadway, 17th Floor
New York, New York 10004
(212) 425-3240

C. Peter Lambos
Donato Caruso*
LAMBOS & JUNGE
29 Broadway, 9th Floor
New York, New York 10006
(212) 943-2470

Co-Counsel to Respondents
(Counsel of Record)*

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The following opinions and orders have been omitted in printing this joint appendix because they appear on the following pages of the appendix to the printed petition for a writ of certiorari.

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Civil Docket for Case#: 92-CV-2779

4/16/92	1	COMPLAINT filed; Summons issued and Notice pursuant to 28 U.S.C. 636(c); FILING FEE $120.00 RECEIPT # 166349 (1a) [Entry date 04/22/92]
6/9/92	10	Rule 3(g) statement filed by David Axelrod, Lorna H. McBarnette, Steven C. Anderman (jh) [Entry date 06/10/92]
6/9/92	11	ANSWER to Complaint by David Axelrod, Lorna H. McBarnette, Steven C. Anderman (Attorney Richard Corenthal); Firm of: Robert Abrams by attorney Richard Corenthal for defendant David Axelrod (jh) [Entry date 06/10/92]
7/31/92	12	MEMORANDUM by David Axelrod, Lorna H. McBarnette, Steven C. Anderman in support of Defendants' Motion for Summary Judgment (sc) [Entry date 08/03/92]
7/31/92	13	AFFIDAVIT in support of Richard Corenthal by David Axelrod, Lorna H. McBarnette, Steven C. Anderman Re: Defendants' Motion for Summary Judgment (sc) [Entry date 08/03/92]
7/31/92	14	AFFIDAVIT of Richard Pellegrini by David Axelrod, Lorna H. McBarnette, Steven C. Anderman Re: (sc) [Entry date 08/03/92]
9/24/92	16	NOTICE OF MOTION by NYSA-ILA Medical and for summary judgment, Return date (jh)

9/24/92	17	MEMORANDUM by NYSA-ILA Medical and in support of [16-1] motion for summary judgment (jh)
10/21/92	19	MEMORANDUM by David Axelrod, Lorna H. McBarnette, Steven C. Anderman in opposition to [16-1] motion for summary judgment (jh) [Entry date 10/22/92]
11/4/92	20	REPLY MEMORANDUM of law by NYSA-ILA Medical and (jh)
2/23/93	21	MEMORANDUM OPINION # 71096 denying [16-1] motion for summary judgment (Signed by Judge John S. Martin); Copies mailed. (jh) [Entry date 02/25/93]
3/1/93	22	JUDGMENT # for Lorna H. McBarnette, Steven C. Anderman, David Axelrod against NYSA-ILA Medical and Clinical Services Fund The complt is dismissed etc (James M. Parkison, Clerk); Mailed copies and notice of right to appeal. (jh) [Entry date 03/02/93]
3/1/93	—	Case closed (jh) [Entry date 03/02/93]
3/16/93	23	NOTICE OF APPEAL by NYSA-ILA Medical and; from [22-1] judgment order. Copies of notice of appeal mailed to Attorney(s) of Record: Richard Corenthal, Jane Baker and Robert Abrams. (jf)
4/29/93	26	MANDATE OF USCA (certified copy) Re: the appeal shall be deemed withdrawn with prejudice (jh) [Entry date 07/08/93]
11/1/93	29	True Copy of Order from the USCA as to Lorna H. McBarnette, Steven C. Anderman, David Axelrod RE: [0-0] transmitted appeal reinstate the appeal in the above matter (jh) [Entry date 01/24/94]

11/1/93	—	Appeal reinstated by NYSA-ILA Medical and [23-1] appeal by NYSA-ILA Medical and USCA NUMBER: 93-7221 (jh) [Entry date 01/24/94]
7/19/94	30	MANDATE OF USCA (certified copy) Re: [0-1] appeal by NYSA-ILA Medical, etc.: It is hereby ordered, adjudged and decreed that the judgment of the district court be and it hereby is reversed in accordance with the opinion of this court. Bill of costs in favor of appellants NYSA-ILA Med. Clinical Svces. Fund etc., in the amount of $1,366.40 attached. GEORGE LANGE III, Clerk, U.S.C.A. (em)
5/4/95	33	ORDER, adjourning pretrial conference sine die, and counsel for the plaintiff shall inform the Court at such time as the Second Circuit renders a decision in this matter (signed by Judge Denise L. Cote); Copies mailed (jr) [Entry date 05/10/95]
2/7/96	35	MANDATE OF USCA (certified copy) Re: On consideration whereof, it is now hereby ordered, adjudged and decreed that the judgment of the district court be and it hereby is reversed and remanded to the district court for further proceedings in accordance with the opinion of this court. (93-7221). GEORGE LANGE III, Clerk, U.S.C.A. (em)
2/7/96	36	Bill of costs in favor of the Appellant, NYSA-ILA Medical & Clinical Svces. Fund in the amount of $246.82. (93-7221). GEORGE LANGE III, Clerk, U.S.C.A. (em)

2/7/96 — DOCKETED AS A JUDGMENT # 96,0253 ON 2/8/96. ENDORSED ON DOC# 36 (kk) [Entry date 02/08/96]

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
WASHINGTON, D.C. 20543

October 15, 1996

Ms. M. Patricia Smith
Assistant Attorney General
120 Broadway
New York, NY 10271

Re: Barbara A. De Buono, New York Commissioner of Health, et al.
v. NYSA-ILA Medical and Clinical Services Fund, etc., et al.
No. 95-1594

Dear Ms. Smith:

The Court today entered the following order in the above entitled case:

The petition for a writ of certiorari is granted.

Sincerely,

/s/ WILLIAM K. SUTER
William K. Suter, Clerk

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 1294—August Term 1993

On remand from Supreme Court

(Submitted November 15, 1995 Decided January 4, 1996)
Docket No. 93-7221

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Plaintiffs-Appellants,

—v.—

DAVID AXELROD, M.D., in his capacity as New York State Commissioner of Health; LORNA H. MCBARNETTE, in her capacity as New York State Executive Deputy Commissioner of Health; STEVEN C. ANDERMAN, in his capacity as Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Defendants-Appellees.

Before:

WALKER and JACOBS, *Circuit Judges*,
and ZAMPANO, *District Judge*.*

PER CURIAM:

On June 23, 1994, we entered a judgment and filed an opinion, *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 27 F.3d 823, which reversed a summary judgment entered February 23, 1993 by the United States District Court for the Southern District of New York (John S. Martin, Jr., *Judge*). The district court had held that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, did not preempt New York's Health Facility Assessment ("HFA"), N.Y. Pub. Health Law § 2807-d, reasoning that the tax imposed by the HFA "is not great enough to pose a serious economic threat to the plan." In reversing, we held that the HFA directly affected and was therefore "related to" the Fund in its principal role as an employee welfare plan.

On May 1, 1995, the Supreme Court entered an order granting certiorari, vacating the judgment of this court, and remanding the case to us for further consideration in light of *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995), *rev'g* 14 F.3d 708 (2d Cir. 1994). *See Chassin v. NYSA-ILA Medical & Clinical Servs. Fund*, 115 S. Ct. 1819 (1995).

We ordered counsel for the parties to brief the issue of whether *Travelers* requires a different result in this case.

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* Honorable Robert C. Zampano, United States District Judge for the District of Connecticut, sitting by designation. Judge Zampano retired shortly after oral argument was heard in this case. Accordingly, the appeal was decided by the remaining panel members pursuant to Section 0.14 of the Local Rules of the Second Circuit.

Upon receipt of these briefs, we carefully reconsidered this case in light of *Travelers*. For the reasons that follow, we adhere to our original decision reversing the judgment of the district court.

The undisputed facts in this case have been set forth both in the district court opinion and in our original opinion, and we therefore do not fully restate them here. The Trustees of NYSA-ILA Medical & Clinical Services Fund (the "Fund") brought this suit seeking a declaration that ERISA preempts New York Public Health Law § 2807-d to the extent that the HFA taxes contributions and other payments for health care benefits received by two medical centers operated by the Fund. On appeal, we found that the HFA directly "relates to" the Fund in that "[t]he tax depletes those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received." *Axelrod*, 27 F.3d at 827.

Upon reconsideration in light of the Supreme Court's holding in *Travelers*, we conclude that the ground upon which our earlier decision in this case rested remains undisturbed. *Travelers* involved a challenge to New York's imposition of a surcharge on hospital bills paid by commercial insurers and Health Maintenance Organizations but not on hospital bills paid by Blue Cross/Blue Shield insurers. The statute at issue in *Travelers* did not impose surcharges on ERISA plans themselves, but on insurance carriers providing health insurance coverage to the plans and their beneficiaries. The surcharge consequently raised costs to the patient, who remained liable for the balance of any bill an ERISA plan or insurance carrier refuses to pay. The Supreme Court concluded that "a law operating as an indirect source of merely economic influence on administrative decisions [by ERISA plans], as here, should not suffice to trigger pre-emption." *Travelers*, 115 S. Ct. at 1680.

The facts of the present case distinguish it from *Travelers*, because, unlike in *Travelers*, there is no third party between the plan and the tax imposed pursuant to the HFA. Rather, the statute at issue depletes the Fund's assets directly, and thus has an immediate impact on the operations of an ERISA plan. As we observed in our original opinion, the HFA imposes "an immediate tax on payments and contributions which were intended to pay for participants' medical benefits . . . [and] thus directly affects the Fund in its principal role as an employee welfare benefit plan." *Axelrod*, 27 F.3d at 827.

Nothing in *Travelers* undermines our reliance on the HFA's direct economic impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of pre-emption. Because our reasoning is not inconsistent with the Supreme Court's opinion in *Travelers*, we adhere to our original disposition that reversed and remanded this case.

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 1294—August Term 1993

(Argued March 10, 1994 Decided June 23, 1994)

Docket No. 93-7221

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, By Its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Plaintiffs-Appellants,

—v.—

DAVID AXELROD, M.D., in his capacity as New York State Commissioner of Health; LORNA H. MCBARNETTE, in her capacity as New York State Executive Deputy Commissioner of Health; STEVEN C. ANDERMAN, in his capacity as Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Defendants-Appellees.

Before:

WALKER and JACOBS, *Circuit Judges*, and ZAMPANO, *District Judge*.*

WALKER, *Circuit Judge*:

The Trustees of NYSA-ILA Medical & Clinical Services Fund (the "Fund") brought this suit seeking a declaration that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, preempts New York Public Health Law § 2807-d to the extent the latter provision taxes contributions and other payments for health care benefits received by two medical centers operated by the Fund. The Fund now appeals from a judgment of the United States District Court for the Southern District of New York (John S. Martin, Jr., *Judge*) holding that ERISA does not preempt the state tax and granting summary judgment to defendant state health care officials. We reverse.

BACKGROUND

The Fund is an ERISA-regulated multiemployer, labor-management trust fund established through collective bargaining to administer an employee welfare benefit plan that provides medical, dental, and other health care services to ERISA plan participants, consisting primarily of longshore workers, and their dependents. The Fund provides these health care benefits through three medical centers that it owns and operates, two in

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* Honorable Robert C. Zampano, United States District Judge for the District of Connecticut, sitting by designation. Judge Zampano retired shortly after oral argument was heard in this case. Accordingly, the appeal was decided by the remaining panel members pursuant to Section 0.14 of the Local Rules of the Second Circuit.

New York and one in New Jersey. The centers provide treatment exclusively to plan participants and beneficiaries.

In 1990, the State of New York enacted a Health Facility Assessment ("HFA"), which imposed a tax on the gross receipts from patient care services and general operations of all hospitals in New York State. N.Y. Pub. Health Law § 2807-d. The HFA was enacted to help eliminate the State's budget deficit for the 1990-91 fiscal year. The HFA became effective January 1, 1991, and was supposed to expire on April 1, 1992, but has subsequently been amended to remain in force on and after that date. 1992 N.Y. Laws, ch. 41, §§ 54, 163. The HFA applies to a wide range of medical facilities, including diagnostic and treatment centers such as the medical centers operated by the Fund. N.Y. Pub. Health Law § 2801(1). The amount of the assessment, which varies by type of facility, is six-tenths of one percent for the Fund's medical centers. *Id.* § 2807-d(2)(c). For purposes of the assessment, "gross receipts" are defined as "all monies received for or on account of hospital and health related services" with only limited exceptions. *Id.* § 2807-d(3)(c).

The Fund's medical centers receive income from a variety of sources. The bulk of their costs are covered by employer contributions remitted to the Fund which are then transferred to the centers on an as-needed basis to pay for the centers' payroll and other operating expenses. However, the centers obtain additional revenue from certain employer payments made directly to the centers, employee co-payments, other fee-for-service payments, patient registration fees, payments from workers' compensation carriers, and such miscellaneous sources as the sale of scrap or waste, fees for reproducing medical records, and supplier rebates. For the period from January 1, 1991 to November 30, 1991, the Fund's two New York medical centers reported combined assessable income of $1,177,670 and paid assessments totalling $7,066. The Fund discontinued filing HFA reports with the New York State

Department of Health after November 1991 and has paid no assessments since that time.

The medical centers did not include in their assessable income monies transferred from the Fund to the centers, and the State defendants have not contested the exclusion of these payments in this case. However, the question of whether monies transferred from the Fund to the centers are assessable has never, to our knowledge, been litigated or definitively resolved. Since early 1992, the Fund has restructured its payment procedures so that certain employer contributions and registration fees that were formerly paid directly to the medical centers are now remitted to the Fund itself. The Fund believes that this restructuring avoids the effect of the HFA, but is unwilling to redirect to the Fund all payments now received by the medical centers until this case has been decided.

The Fund instituted this suit in April 1992 asserting that ERISA preempts the HFA insofar as it imposes a levy on contributions and payments for health care benefits provided by the Fund. The Fund does not challenge imposition of the HFA on the centers' miscellaneous revenue earned from activities unrelated to the health care services provided to participants and beneficiaries, such as the income derived from the sale of scrap, records reproduction fees, and supplier rebates. The Fund sought declaratory and injunctive relief as well as restitution of a substantial portion of the HFA assessments it had previously paid.

On cross-motions for summary judgment, the district court ruled that the HFA is a tax of general application that is not preempted by ERISA because it has only an incidental impact on ERISA plans. The district court reasoned that the minimal tax imposed by the HFA "is not great enough to pose a serious economic threat to the plan which might trigger preemption." *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 92 Civ. 2279 (JSM), slip op. at 8 (S.D.N.Y. Feb. 18, 1992). Accordingly, the district court entered judgment dismissing the action and this appeal ensued. We review the district court's

decision *de novo*. *See Westinghouse Elec. Corp. v. New York City Transit Auth.*, 14 F.3d 818, 821 (2d Cir. 1994).

DISCUSSION

ERISA was enacted in 1974 "to promote the interests of employees and their beneficiaries in employee benefit plans," including both pension and welfare plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). An "employee welfare benefit plan" is defined in the statute as

> any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . .

29 U.S.C. § 1002(1). The parties do not dispute that the Fund qualifies as an employee welfare benefit plan that fulfills its institutional mission by providing medical benefits directly to plan participants and their beneficiaries through Fund-operated medical centers.

One of ERISA's main objectives was to eliminate state regulation of employee benefit plans. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990); *Shaw*, 463 U.S. at 99 (quoting legislative history). To accomplish this, Congress enacted an express preemption clause that is "deliberately expansive." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987). It provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the law. 29 U.S.C. § 1144(a). The Supreme Court has observed that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."

Shaw, 463 U.S. at 96-97. Preemption thus applies even where a state law was not specifically designed to regulate the terms and conditions of employee benefits plans or does not relate to those subjects covered by ERISA, such as reporting, disclosure, and fiduciary responsibilities. *See Ingersoll-Rand Co.*, 498 U.S. at 137-39; *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990); *Shaw*, 463 U.S. at 98. Indeed, even where a state law has no express link to an employee benefit plan, it can be preempted " 'insofar as' the law applies to benefit plans in particular cases." *Morgan Guar. Trust Co. v. Tax Appeals Tribunal*, 80 N.Y.2d 44, 49 (1992) (quoting *Shaw*, 463 U.S. at 97 n.17).

ERISA preemption is not without limitations, however. The Supreme Court has recognized that ERISA preemption will not apply to state laws that "affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. When it announced this limitation, the Court "express[ed] no views about where it would be appropriate to draw the line," *id.*, but it has subsequently observed that this limitation will apply "with many laws of general applicability," *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 583 n.1 (1992). There are a number of cases that bear out this observation. *See, e.g., Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (generally applicable garnishment law not preempted); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (state law requiring one-time severance payment not preempted); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.) (state escheat law not preempted when applied to recover unclaimed ERISA plan benefits), *cert. denied*, 493 U.S. 811 (1989); *see also Matter of Dyke*, 943 F.2d 1435, 1447 (5th Cir. 1991) (collecting cases). Unfortunately, these decisions have provided no sure method for determining whether the HFA's impact on the Fund is too "tenuous, remote, or peripheral" to trigger ERISA preemption.

The State argues that the HFA is a state tax law of general application that affects ERISA plans only incidentally.

According to the State, the HFA is no more directed at ERISA plans than laws implementing sales taxes, utility taxes, and gasoline taxes, and should thus be seen simply as a "cost of doing business" within the state. Relying on *Mackey* and *Aetna Life Ins. Co.*, the State contends that the HFA should not be preempted because it covers ERISA plans only by virtue of the plans' inclusion in a broader class of entities subject to regulation.

However, we believe that the HFA is distinguishable from these laws of general application. The HFA does not apply broadly to every sector of society in New York; nor does it apply to the Fund simply because it engaged in certain kinds of activities which any other member of society might engage in, such as purchasing gasoline or paying one's employees. Rather, the HFA targets only the health care industry. Because this industry is, by definition, the realm where ERISA welfare plans must operate, the HFA was bound to affect them. In a case such as the present one where the plan has chosen to provide medical benefits through self-run medical centers, the HFA operates as an immediate tax on payments and contributions which were intended to pay for participants' medical benefits. The HFA thus directly affects the Fund in its principal role as an employee welfare benefit plan. It does not touch the Fund only slightly on the outer limits of its plan activities; it affects the very operations and functions that make the Fund what it is, a provider of medical, surgical, and hospital care to its participants and their beneficiaries.

We thus conclude that the HFA "relates to" the Fund and does so in a very direct way. The tax depletes those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received. Both impacts will detrimentally affect the central mission and purpose of the Fund and hence cannot be characterized as remote or tenuous. *See Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 720 (2d Cir. 1993) ("[T]he surcharges here force ERISA

plans to increase either plan costs or reduce plan benefits. Therefore, they have the requisite connection to ERISA."), *petition for cert. filed*, 62 U.S.L.W. 3625 (U.S. Mar. 9, 1994) (No. 93-1414); *E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir.) ("The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation."), *cert. denied*, 112 S. Ct. 585 (1991).

Our decision would remain the same even if we assumed that the Fund could avoid the HFA by restructuring its finances so that funds formerly remitted by plan participants and employers directly to the medical centers would be remitted to the Fund which would subsequently transfer them to the centers. Wholly apart from whether the transmission of assets from the Fund to the centers could be taxed without running afoul of ERISA preemption, an issue we need not and do not decide, such a restructuring would alter the Fund's established method of administration and would require it to implement procedures for its New York facilities that differ from those of its New Jersey facility. Moreover, these changes would not be insignificant since they would affect the Fund's primary means of collecting contributions and paying for benefits. A state law that "relates to" an ERISA plan is not saved from ERISA preemption by the fact that a plan could restructure its operations to avoid the impact of the state law. Requirements under state law that force plans to change their traditional methods of administration or to adopt different methods on a state-by-state basis are features of state regulation that ERISA was designed to prevent. *See FMC Corp.*, 498 U.S. at 59-60; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981); *National Carriers' Conference Comm. v. Heffernan*, 454 F. Supp. 914, 918 (D. Conn. 1978) (Newman, J.). *Compare Aetna Life Ins. Co.*, 869 F.2d at 147 (discounting Fund's complaint that it would need to make administrative and accounting adjustments in order to comply with state escheat law because the impact was not substantial enough).

The district court acknowledged that the HFA will directly impact the Fund by leaving less money for benefits, but determined that the magnitude of the impact was too insubstantial to trigger preemption since the tax rate was only .6%. We do no agree with this reasoning. The magnitude of a statute's economic impact on employee benefit plans may enter the analysis where the statute's connection to the ERISA plan is otherwise insufficient for preemption. For example, a real estate gains tax that has only a peripheral connection to ERISA plans may still be subject to preemption if the high rate of tax has a substantial economic impact on a plan. *See Morgan Guar. Trust Co.*, 80 N.Y.2d at 51-53 (ten percent tax on gain from ERISA plan's sale of real property preempted because of direct impact on plan's administration and investment strategy). However, the converse is not true. A statute that "relates to" ERISA plans cannot escape preemption simply because the magnitude of the impact is thought to be insubstantial. Adopting such an approach would contravene the policy that underlies the preemption provision of protecting ERISA plans from state regulation and would open the door to endless litigation about what constitutes a "substantial" impact.

Travelers Insurance Co. v. Cuomo, *supra*, is not to the contrary. In that case, we held that New York surcharges on hospital rates were preempted by ERISA to the extent ERISA plans must pay surcharges. In the course of our analysis, we discussed Judge Martin's opinion in this case without criticizing it. However, we cited it only for the proposition that "a *substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play." 14 F.3d at 721. We did not endorse—and now expressly refuse to endorse—the converse proposition urged by the State: that a regulation which has a *de minimis* economic impact on ERISA plans may withstand preemption regardless of what plan operations it affects.

For the foregoing reasons, we reverse the judgment of the district court.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Civil Action No.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

COMPLAINT

Plaintiffs, the Trustees of the NYSA-ILA Medical and Clinical Services Fund (hereinafter the "Fund"), by their attorneys, Thomas W. Gleason and Lambos & Giardino, as and for their complaint, respectfully allege as follows:

NATURE OF THE ACTION

1. This action seeks relief:

(A) declaring, pursuant to 28 U.S.C. § 2201, that New York Public Health Law § 2807-d is with respect to the plaintiffs, null, void and ineffective under the Supremacy Clause of Article VI of the Constitution of the United States because such provision is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*;

(B) permanently enjoining the defendants from administering and enforcing New York Public Health Law § 2807-d insofar as it requires the plaintiffs to pay any assessments to defendants; and

(C) granting damages to plaintiffs in the amount of all monies paid to defendants pursuant to New York Public Health Law § 2807-d, together with lawful interest thereon.

JURISDICTION

2. Jurisdiction exists pursuant to ERISA § 502, 29 U.S.C. § 1132, and 28 U.S.C. § 1331 in that the dispute arises under the Constitution and Laws of the United States.

VENUE

3. Venue is proper pursuant to 29 U.S.C. § 1132 in that the Fund is administered in the Southern District of New York.

PARTIES

4. The plaintiffs are the Trustees of the Fund. The Fund is a jointly administered, multiemployer, labor-management trust fund established in accordance with Section 302 of the Labor-Management Relations Act of 1949, 29 U.S.C. § 186, and pursuant to an Agreement and Declaration of Trust and

Plan and collective bargaining agreements between New York Shipping Association, Inc. ("NYSA") and the International Longshoremen's Association, AFL-CIO ("ILA"), prescribing the terms and conditions of longshore employment in the Port of New York and New Jersey. At all times material hereto the Fund maintained its principal offices at 2 World Trade Center, 19th Floor, New York, New York 10048-0649.

5. The Fund provides medical, dental and related health care services on an out-patient ambulatory basis to eligible employees and their dependents, and pensioners and their dependents, employed in the port of New York and New Jersey and covered under various collective bargaining agreements negotiated between the NYSA and the ILA, as well as under separate labor agreements between other employers and affiliated locals of the ILA. These benefits are provided through three medical centers owned and operated by the Fund. One is located in the State of New Jersey and two are located in the State of New York. The New York medical centers are located at 600 Avenue of the Americas, New York, New York 10011 and 340 Court Street, Brooklyn, New York 11231.

6. The Fund and its medical centers are an employee benefit plan within the meaning of ERISA §§ 2 (1), 2 (3) and 502 (d) (1), 29 U.S.C. §§ 1002 (1), 1002 (3) and 1132 (d) (1), and are a multiemployer plan within the meaning of ERISA §§ 2 (37) and 515, 29 U.S.C. §§ 1002 (37) and 1145.

7. Defendant David Axelrod, M.D. is the former and most recent New York State Commissioner of Health, and is named since that office is currently vacant. Defendant Lorna H. McBarnette is the New York State Executive Deputy Commissioner of Health. Defendant Steven C. Anderman is the Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health. Defendants David Axelrod, M.D., Lorna H. McBarnette and Steven C. Anderman were and are

charged with the overall general supervision, implementation and administration of New York Public Health Law § 2807-d.

NEW YORK PUBLIC HEALTH LAW § 2807-d

8. The beneficiaries of the Fund pay a $20-per-family annual registration fee and a $5-per-prescription charge. In addition the fund renders medical services to members of the Port Police and Guards Union, the waterfront security guards union, on a fee-for-services basis.

9. New York Public Health Law § 2807-d imposes an assessment on cash receipts of health facilities. Defendants have applied this statute to impose the assessment on plaintiffs.

10. In a letter dated April 19, 1991, plaintiffs advised defendants that they are of an employee benefit plan as defined in ERISA and that the assessment may not be levied on the plan, since the assessment is preempted by ERISA.

11. Plaintiffs have paid approximately $7,065 to defendants under protest.

12. In a letter, dated December 20, 1991 and received by plaintiffs January 2, 1992, defendants, through their counsel, advised plaintiffs that their position was that the assessment was not preempted by ERISA.

13. The Trustees of the Fund determined that to protect the assets of the Fund, no further payments would be made to defendants but that the monies would be placed in escrow pending resolution by the courts.

COUNT I

14. Plaintiff repeats paragraphs 1 through 13 as if fully set forth herein.

15. ERISA § 514 (a), 29 U.S.C. § 1144 (a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514 (c)(1), 29 U.S.C. § 1144 (c)(1), provides that "[t]he term 'State Law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State."

16. New York Public Health Law § 2807-d relates to plaintiffs' plan.

17. New York Public Health Law § 2807-d contravenes Congress's intention to continue the exemption of employee benefit plans from state taxation.

18. For the foregoing reasons, New York Public Health Law § 2807-d is preempted by ERISA and therefore violates the Supremacy Clause of the Constitution of the United States.

WHEREFORE, plaintiffs request that judgment be entered:

1. Declaring New York State Public Health Law § 2807-d null, void and ineffective as applied to plaintiffs;

2. Permanently enjoining the defendants from administering and enforcing New York State Public Health Law § 2807-d insofar as it is applied to plaintiffs;

3. Awarding plaintiffs compensatory damages equal to the amounts paid to defendants; and

4. Interest, costs, disbursements, attorneys' fees and any other and further relief the Court deems just and proper.

Dated: New York, New York
April 16, 1992

THOMAS W. GLEASON

By: KEVIN MARRINAN
Kevin Marrinan (KM 6450)
26 Broadway, 17th Floor
New York, New York 10004
(212) 425-3240

LAMBOS & GIARDINO

By: RICHARD P. LERNER
C. Peter Lambos
Richard P. Lerner (RPL 1881)
29 Broadway, 9th Floor
New York, New York 10006
(212) 943-2470

Co-Counsel to Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

ANSWER

Defendants, by their attorney Robert Abrams, Attorney General of the State of New York, answer the complaint as follows:

FIRST: Neither admit nor deny the allegations contained in paragraphs "1", "2", "3", "15", "17" and "18" of the complaint as they constitute attempts to state conclusions of law to which no answer is required.

SECOND: Deny knowledge and information sufficient to form a belief as to the truth or falsity of the allegations contained in paragraph "4", "6", "8" and "13" of the complaint.

THIRD: Deny knowledge and information sufficient to form a belief as to the truth or falsity of the allegations contained in paragraph "5" of the complaint except admit that plaintiff NYSA-ILA Medical and Clinical Services Fund (the "Fund") provides health care services on an out-patient ambulatory basis through two medical centers which the fund operates in the State of New York and which have been issued operating certificates as diagnostic and treatment centers by the defendant New York State Department of Health pursuant to New York Public Health Law § 2805.

FOURTH: Admit the allegations contained paragraph "7" of the complaint, except allege that defendant Lorna H. McBarnette is currently the acting New York State Commissioner of Health.

FIFTH: Neither admit nor deny the allegations in paragraph "9" of the complaint as they constitute attempts to state conclusions of law to which no answer is required except admit that the requirement that an assessment be charged on the gross cash receipts of a hospital pursuant to New York Public Health Law § 2807-d applies to plaintiffs' medical centers since they are "hospitals" as defined in New York Public Health Law § 2801(1) and the assessment is charged irrespective of whether or not the "hospitals" are operated by a benefit fund qualified under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*.

SIXTH: Admit the allegations contained in paragraph "11" of the complaint except deny knowledge and information sufficient to form a belief as to the truth or falsity of the allegations that plaintiff's payment of approximately $7,065 to defendants was made "under protest" and, in further answer, allege that said payment was deposited in the general fund of the State of New York.

SEVENTH: Admit the allegations contained in paragraph "12" of the complaint except deny knowledge and information as to the date defendants reviewed a letter dated December 20, 1991 which was addressed to the attorneys of the Fund from Peter J. Millock, General Counsel to the New York State Department of Health.

EIGHTH: Deny the allegations contained in paragraph "16" of the complaint.

AS AND FOR A FIRST AFFIRMATIVE DEFENSE

NINTH: The complaint fails to state a claim upon which relief may be granted.

WHEREFORE, defendants respectfully request that the court dismiss the complaint in its entirety and grant all other relief which it deems just and proper.

Dated: June 8, 1992

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Defendants

By: RICHARD CORENTHAL
RICHARD CORENTHAL (RC 4009)
Assistant Attorney General
120 Broadway
New York, New York 10271
(212) 416-8711

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

STATEMENT OF UNDISPUTED MATERIAL FACTS PURSUANT TO LOCAL RULE 3(g)

Defendants, by and through their attorney, Robert Abrams, Attorney General of the State of New York, pursuant to Local Rule 3(g), submit this Statement of Undisputed Material Facts in support of a motion for summary judgment.

1. The plaintiff NYSA-ILA Medical and Clinical Services Fund ("the Fund") operates two medical centers in the State of New York which have been issued operating certificates as diagnostic and treatment centers by the defendant New York State Department of Health ("the Department") pursuant to New York Public Health Law § 2805.

2. As licensed diagnostic and treatment centers, the medical centers are "[h]ospitals", as defined in New York Public Health Law § 2801(1), and are charged an assessment on their gross cash receipts received from all patient care services and other operating income by the Department pursuant to New York Public Health Law § 2807-d.

3. The hospital assessment under New York Public Health Law § 2807-d applies to "[h]ospitals" as defined in New York Public Health Law § 2801(1) irrespective of whether or not such hospitals are operated by a benefit fund qualified under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*.

4. The Department has designated Blue Cross of Central New York, Inc. ("BCCNY") to act as the Department's administrative agent for collecting the assessments on hospitals' gross cash receipts authorized by New York Public Health Law § 2807-d. The Department has instructed "[h]ospitals", as defined in New York Public Health Law § 2801(1), including plaintiffs' two medical centers, to forward such hospital assessments on a monthly basis to BCCNY and BCCNY, in turn, forwards such monies to the general fund of the State of New York ("the State") pursuant to New York Public Health Law § 2807-d(9).

5. Defendants have paid $7,066.02 to the general fund of the State pursuant to New York Public Health Law § 2807-d(g).

Dated: New York, New York
June 8, 1992

Respectfully submitted,

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Defendants

By: RICHARD CORENTHAL
RICHARD CORENTHAL (RC 4009)
Assistant Attorney General
120 Broadway
New York, New York 10271
(212) 416-8711

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

AFFIDAVIT IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

STATE OF NEW YORK)
: SS.:
COUNTY OF NEW YORK)

RICHARD CORENTHAL, being duly sworn, deposes and says:

1. I am an Assistant Attorney General and Deputy Chief of the Labor Bureau on the staff of Robert Abrams Attorney General of the State of New York, attorney for the defendants herein.

2. This affidavit is submitted in support of the defendants' motion for summary judgment.

3. I have reviewed the "bill jacket" for Senate Bill 9190 maintained in the N.Y.S. Department of Law's Albany library. Exhibit A hereto. This bill, which was enacted as Chapter 938 to the Laws of 1989, and codified as N.Y. Public Health Law § 2807-d (PHL § 2807-d), authorizes an assessment on the monthly gross cash receipts of hospitals covered by Article 28 of the Public Health Law, including Article 28 diagnostic and treatment centers.

4. According to the report of the New York State Division of Budget submitted to the New York State Legislature in support of Senate Bill 9190, the bill's purpose was to generate revenue to help eliminate the deficit for the 1990-91 fiscal year and achieve savings in the State's Medicaid program.

5. The effective date of the assessment under PHL § 2807-d as originally enacted was January 1, 1991 and expired on April 1, 1992. A subsequent amendment to PHL § 2807-d enacted a "sunset" provision whereby the expiration date of PHL § 2807-d was extended to March 31, 1993. L. 1992, ch.41, § 162. Exhibit B hereto.

/s/ RICHARD CORENTHAL
RICHARD CORENTHAL (RC 4009)
Assistant Attorney General

Sworn to before me on
the 30th day of July, 1992

/s/ Jennifer S. Brand
Assistant Attorney General

CHAPTER 938

LAWS OF 1990 _____ MEMORANDUM NO. _____

SENATE BILL 9190 ASSEMBLY BILL _____

S. 9190 A. 12232

SENATE — ASSEMBLY

December 13, 1990

IN SENATE—Introduced by COMMITTEE ON RULES—read twice and ordered printed, and when printed to be committed to the Committee on Finance

IN ASSEMBLY—Introduced by COMMITTEE ON RULES—read once and referred to the Committee on Ways and Means

AN ACT to amend the public health law, the social services law and the mental hygiene law, in relation to assessing certain health care providers; and making an appropriation therefor: to amend the social services law, in relation to establishing the utilization control program; making an appropriation therefor: and to repeal certain provisions of the public health law; to create a temporary task force on hospital reimbursement and child health insurance issues and to amend chapter 266 of the laws of 1986, amending the civil practice law and rules relating to medical and dental malpractice; and repealing certain provisions of the public health law, the social services law and the mental hygiene law upon the expiration thereof.

DATE RECEIVED BY GOVERNOR:

12/14

ACTION MUST BE TAKEN BY:

12/26

DATE GOVERNOR'S ACTION TAKEN:

DEC. 21 1990

SENATE VOTE 47 Y 7 N HOME RULE MESSAGE __ Y ✔ N

DATE 12/13/90 BILL IS DISAPPROVED

ASSEMBLY VOTE 86 Y 52 N DATE _____

DATE 12/13/90 _____

COUNSEL TO THE GOVERNOR

NEW YORK STATE ASSEMBLY
TWO HUNDRED THIRTEENTH SESSION

REPRINT
DATE: 12/13/90

DATE: 12/13/1990
TIME: 11:59:59 PM

BILL: S9190 (A12232) R.R. NO: 1399 SPONSOR: RULES

Provides for assessments upon health care providers; appropriations; repealers

MESSAGE OF NECESSITY

Y	Abbate PJ	*NAY*	*Cochrane JC*
ABS	Abramson E	Y	Colman S
NAY	*Anderson RR*	Y	Connelly EA
NAY	*Balboni MA*	Y	Conners RJ
Y	Barbaro FJ	*NAY*	*Conte JD*
ABS	*Barnett HW*	*NAY*	*Cooke AT*
Y	*Barraga TF*	*NAY*	*Coombe RI*
NAY	*Becker GR*	Y	Crowley J
NAY	*Behan JL*	*NAY*	*D'Andrea RA*
Y	Bennett LE	Y	Daniels GL
Y	Bianchi IW	*NAY*	*Davidsen DR*
NAY	*Bonacic JJ*	Y	Davis G
Y	Boyland WF	Y	Dearie JC
Y	Bragman MJ	Y	Del Toro A
Y	Brennan JF	Y	Diaz HL
Y	Brodsky RL	Y	DiNapoli TP
NAY	*Brown HC*	Y	Dugan EC
NAY	*Bush WE*	*NAY*	*Eannace RJ*
NAY	Butler DJ	Y	Eve AO
Y	Canestrari RJ	Y	Farrell HD
NAY	*Casale AJ*	*NAY*	*Faso JJ*
Y	Catapano TF	Y	Feldman D
ABS	*Chesbro RT*	*NAY*	*Flanagan JJ*
Y	Clark RM	Y	Friedman G

NAY	*Frisa D*	Y	Marshall HM
NAY	*Gaffney RJ*	Y	Martinez I
Y	Gauti DF	Y	Mayersohn N
Y	Genovesi AJ	*ABS*	*McCann JW*
Y	Gottfried RN	*NAY*	*McGee PK*
Y	Graber VJ	*NAY*	*Miller RH*
Y	Grannis A	Y	Murphy MJ
Y	Green RL	Y	Murtaugh JB
Y	Greene A	Y	Nadler J
Y	Griffith K	*NAY*	*Nagle JF*
Y	Haremberg PE	Y	Nolan CT
ABS	*Harris GH*	EOR	Norman C
NAY	*Hasper J*	*NAY*	*Nortz HR*
NAY	*Hawley RS*	*NAY*	*Nozzolio MF*
NAY	*Healey PB*	*NAY*	*O'Neil JG*
Y	Heveal AG	*NAY*	*Ortloff C*
ABS	Hikind D	*NAY*	*O'Shea CJ*
Y	Hill KH	Y	Parment WL
Y	Hillman MC	*NAY*	*Parola FE*
Y	Hinchey MD	Y	Passanmante WF
NAY	*Holland JR*	*NAY*	*Pataki GE*
Y	Hoyt WB	Y	Phoffer AI
Y	Jacobs RS	Y	Pillittare JT
Y	Jenkins C	Y	Pordum FJ
Y	Kaufman SB	*NAY*	*Prescott DW*
Y	Keane RJ	*NAY*	*Proskin AW*
NAY	*Kelleher NW*	Y	Proud G
NAY	*King RL*	*NAY*	*Rappleyea CD*
Y	Koppell GO	*NAY*	*Reynolds TM*
Y	Lafayette IC	Y	Robach RJ
EOR	*Larkin WJ*	Y	Rosado D
Y	Lasher HL	*NAY*	*Saland SM*
NAY	*Leibell VL*	Y	Sandera S
Y	Lentol JR	*ABS*	*Sawicki J*
Y	Lopez VJ	Y	Schimminger RL
Y	Luster MA	NAY	Schmidt FD
NAY	*Madison GH*	Y	Seabrook L

NAY	*Sears WR*	Y	Tonko PD
Y	Seminerio AS	Y	Vann A
ABS	Siegel MA	Y	Vitalinno EN
Y	Silver S	*NAY*	*Warren GE*
NAY	*Singer CD*	Y	Weinstein HE
NAY	*Straniere RA*	Y	Weisenberg H
Y	Sullivan EC	Y	Weprin S
EOR	*Sullivan PM*	*NAY*	*Wertz RC*
Y	Sweeney RK	*NAY*	*Winner GH*
Y	Tallon JR	Y	Yevoli LJ
NAY	*Talomie FG*	Y	Young GP
NAY	*Tedisco J*	Y	Zaleski TM
Y	Tocci RC	Y	Zimmer MN
Y	Tokass P		Mr. Speaker

YEAS: 86 NAYS: 52

CONTROL: 25410634

CERTIFICATION: /s/ FRANCINE M. MISASI
CLERK OF THE ASSEMBLY

Legend: Y=YES, NAY=NO, NV=ABSTAIN, ABS=ABSENT,
ELB=EXCUSED FOR LEGISLATIVE BUSINESS,
EOR=EXCUSED FOR OTHER REASONS

SENATE

This Senate Bill — Senate No. 9190

by Sen. RULES — Assem. Rept. No. _____

Calendar No. 1959

Entitled: AN ACT to amend the public health law, the social services law and the mental hygiene law, in relation to assessing certain health care providers; and making an appropriation therefor; to amend the social services law, in relation to establishing the utilization control program; making an appropriation therefor; and to repeal certain provisions of the public health law; to create a temporary task force on hospital reimbursement and child health insurance issues and to amend chapter 266 of the laws of 1986, amending the civil practice law and rules relating to medical and dental malpractice; and repealing certain provisions of the public health law, the social services law and the mental hygiene law upon the expiration thereof

No. 1 [THREE DAY MESSAGE OF GOVERNOR]

The President put the question whether the Senate would agree to final passage of said bill, and the facts which necessitate an immediate vote thereon having been certified by the Governor, the same being upon the desks of the members in final form, it was decided in the affirmative, a majority of all the members elected voting in favor thereof and three-fifths being present as follows:

	Dist.		NAY	AYE
	17	*Mr. Babbush*		
	43	Mr. Bruno		
	25	*Mr. Connor*		
	40	Mr. Cook		
	61	Mr. Daly	EXCUSED	
	47			
	44	Mr. Farley		
	31	*Mr. Galiber*	_____	
	13	*Mr. Gold*		
	32	*Mr. Gonzalez*		
	37	Mrs. Goodhue	EXCUSED	
	26	Mr. Goodman		
	39	*Mr. Gray*		
	18	*Mr. Halperin*		
	6	Mr. Hannon		
	48	*Ms. Hoffmann*	_____	
	10			
	4	Mr. Johnson		
	53	Mr. Kehoe		
	33	*Mr. Korman*		
	52	Mr. Kuhl		
	2	Mr. Lack		
	1	Mr. LaValle		
	28	*Mr. Leichter*	_____	
	38			
	8	Mr. N. Levy		
	51	Mr. Libous		

	Dist.	(cont.)	NAY	AYE
	49	Mr. Lombardi		
	15	Mr. Maltese		
	24	Mr. Marchi		
	5	Mr. Manno		
	21	*Mr. Markowitz*		
	58	*Mr. Masiello*	—	
	46	Mr. McHugh		
	23	Mr. Mega		
	30	*Mrs. Mendez*		
	22	*Ms. Montgomery*	—	
	42	*Mr. Nolan*	—	
	27	*Mr. Ohrenstein*		
	14	*Mr. Onorato*		
	36	*Mrs. Oppenheimer*		
	11	Mr. Padavan		
	29	*Mr. Paterson*		
	54	*Mr. Perry*	EXCUSED	
	56	Mr. Present		
	55	*Mr. Quattrociocchi*		
	41	Mr. Rolison		
	50	Mr. Seward		
	60	Mr. Sheffer		
	9	Mr. Skelos		
	20	*Miss Smith*		
	19	*Mr. Solomon*	EXCUSED	
	35	Mr. Spano		
	57	*Mr. Stachowski*	—	

	Dist.	(cont.)	NAY	AYE
	45	Mr. Stafford		
	12	*Mr. Stavisky*		
	3	Mr. Trunzo		
	7	Mr. Tully		
	34	Mr. Velella		
	59	Mr. Volker		
	16	*Mr. Weinstein*		

AYES 47

NAYS 7

Ordered, that the Secretary deliver said bill to the Assembly and request its concurrence therein.

Session Year 1990

BUDGET REPORT ON BILLS

SENATE

No. S.9190

ASSEMBLY

No. A

Law: Public Health
Mental Hygiene
Social Services

The main provisions of this bill:

— assess hospitals and other health care providers six-tenths of one percent of their gross revenues through March 31, 1992, to help offset the costs of trend factor increases and other rate enhancements;

— provide supplementary bad debt and charity care rate adjustments through March 31, 1992, for hospitals with high percentages of Medicaid and indigent care discharges;

— make technical amendments to Chapters 922 and 923 of the Laws of 1990 governing reimbursement to hospitals for rate years 1991-1993;

— reduce Medicaid reimbursement for the 1991 inpatient rates to reflect the allowable statutory case-mix increase limits;

— reconfigure bad debt and charity care fund distributions as State Medicaid expenditures;

— authorize a program of Medicaid utilization controls for Home Relief recipients through March 31, 1992.

Other provisions of the bill conform income and resource Medicaid eligibility criteria to federal requirements; reduce adjustments to payment levels for prescription drugs from a

monthly to a biannual cycle; require submission of Medicaid claims within two years of date of service without exception; access $8 million in interest earned from the Bad Debt and Charity Care Pool funds, $1.7 million from the Professional Medicaid Conduct Special Revenue Account, and $10 million in surplus from the Medical Malpractice Excess Insurance funds as a one-time offset to State Medicaid costs; and authorize a loan of up to $62 million from the Bad Debt and Charity Care Pool funds to cover current year Medicaid liabilities.

Since enactment of this bill is necessary to eliminate the deficit for the 1990-91 fiscal year and achieve savings in the Medicaid program in 1991-91 and since a chapter amendment will be enacted to correct a technical flaw relating to the varied assessments for hospitals, we recommend approval of this bill.

12/18/90

/s/ [ILLEGIBLE]

[LETTERHEAD OF MEDICAL SOCIETY OF THE STATE OF NEW YORK]

December 20, 1990

Honorable Mario M. Cuomo
Governor of the State of New York
Executive Chamber
State Capitol
Albany, New York 12224

Dear Governor Cuomo:

We understand that you now have before you for consideration S.9190/A.12232, the recently negotiated deficit reduction proposal for the Medicaid program. Included in this proposal is authorization for the Commissioner of Social Services to implement a program of Medicaid Utilization Thresholds (MUTS). We urge that this provision of the legislation not be approved.

As you are well aware, utilization thresholds for Medicaid patients has been a highly controversial proposal for several years. While we appreciate that some of our concerns and recommendations for improvements to the program have been recognized and incorporated into its current form, we remain seriously concerned about MUTS' potential to be detrimental to quality of care, further erode physician relationship with the Medicaid program, and deter patients from seeking appropriate and much needed health care services. In brief, our opposition to MUTS can be summarized as follows:

- The program imposes an arbitrary maximum limit to health care for the poor;

- The program would create an incentive for shifting medical care from the less costly private setting to hospital emergency rooms;

- There is a potential for significant implementation problems in that the program does not encompass an appropriate recourse for the verification and authorization of medical care if the "system" encounters a functional problem (as it inevitably will, e.g., the computer network can malfunction, telephone lines can jam, staff determinations can backlog);

- The aforementioned functional problems would lead to an ethical dilemma regarding the treatment of patients whose eligibility for care cannot be verified;

- The addition of onerous eligibility and verification processes to an already abysmally low reimbursement schedule would discourage current and future providers and inhibit access to care; and

- Finally, the proposal is contradictory to New York State's public policy objectives of expanded access to quality health care for all New Yorkers. This program would arbitrarily segregate a segment of New York State's Medicaid population and limit services available to those persons. For this segment of the Medicaid population, this program represents nothing less than RATIONING OF MEDICAL AND HEALTH CARE SERVICES.

We, of course, recognize that New York State's fiscal condition warrants painful choices and that fiscally responsible policies are warranted to address the State's fiscal deficit. To this end, we would recommend that, in lieu of MUTS, the State could pursue other policy options. These recommendations include:

- Meaningful reform of the medical liability system. It is unconscienable to limit service to the poor when 20% of our health care dollar is being squandered on a

grossly inefficient system that does not appropriately meet the needs of any of the system's participants;

• Strengthen existing fraud and abuse activities with regard to providers but with complete and full protection of the due process rights of physicians;

• Strengthen the restricted service program for over-utilizing patients;

• Expand funding for alternate care programs, e.g. managed care; and

• Creation of a study commission to examine the total restructuring of the Medicaid program.

We cannot overstate our concern for the serious negative impact that this program would have on the Medicaid program and the harm it would cause to the quality and availability of medical services to poor New Yorkers. For the above-mentioned reasons, we respectfully request that you use your veto authority to disapprove this initiative.

Respectfully,

/s/ ROBERT A. MAYERS, M.D.
ROBERT A. MAYERS, M.D.
President

/s/ DONALD F. FOY
DONALD F. FOY
Executive Vice-President

/s/ GERARD L. CONWAY
GERARD L. CONWAY, ESQ.
Director

UNITED STATE DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—v.—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

AFFIDAVIT

STATE OF NEW YORK)
COUNTY OF ALBANY)ss.:

RICHARD PELLEGRINI, being duly sworn, deposes and says:

1. I am Director of the Bureau of Financial Management and Information Support, New York State Department of Health ("Department") and, as such, I am familiar with the facts hereinafter set forth.

2. New York Public Health Law ("PHL") § 2807-d is a revenue raising measure that imposes a percentage assessment on hospital gross receipts. This assessment is imposed on all hospitals in New York with certain narrowly designed exceptions relating to financially distressed institutions. See PHL § 2807-d(1). "Hospitals" as defined in PHL 2807-d and in PHL Article 28 generally (see PHL § 2801(1)) encompass a variety of medical institutions, including diagnostic and treatment centers issued operating certificates pursuant to PHL § 2805. The two clinics operated by plaintiff in New York and referenced in the Complaint herein are PHL Article 28 licensed diagnostic and treatment centers and, as such, they come within the provisions of the gross receipts assessment provisions of PHL § 2807-d.

3. The Department has designated Blue Cross of Central New York, Inc. (BCCNY) to act as the Department's administrative agent for collecting these assessments. Hospitals have been instructed to forward such assessments on a monthly basis to BCCNY and BCCNY in turn forwards said monies to the State's general fund. These instructions are contained in a letter dated 1/24/91 which was sent by the Department to all affected health care facilities in New York. A copy of this letter of 1/24/91 is annexed hereto as Exhibit A.

4. The provisions of PHL 2807-d apply to plaintiffs' clinics solely because they are "hospitals" as defined in Article 28 of the Public Health Law and the provisions of PHL 2807-d apply to almost all hospitals. The status of these facilities as "hospitals" is in turn based on the nature of the medical services they provided. The fact that these clinics are

operated by an ERISA qualified union benefits fund is entirely irrelevant to their status as "hospitals" and to the fact that, as hospitals, they come within the ambit of PHL § 2807-d.

/s/ RICHARD PELLEGRINI
RICHARD PELLEGRINI

Sworn to before me this
11th day of June, 1992

/s/ ROBERT A. _____
Notary Public

ROBERT A. _____
Notary Public, State of New York
Qualified in Albany County
4667994
Commission Expires 5/31/94

[LETTERHEAD OF STATE OF NEW YORK
DEPARTMENT OF HEALTH]

January 24. 1991

RE: Health Facility Cash Receipt
Assessment Program

Dear Administrator/Comptroller:

The following will provide the necessary instructions for health care provider compliance with Chapter 938 of the Laws of 1990 which requires the payment of an assessment on cash operating receipts for the period January 1, 1991–March 31, 1992. This assessment was enacted by the New York State Legislature and signed into law by the Governor as an alternative to substantial Medicaid payment reductions which were considered necessary to resolve the State's current fiscal crisis

The providers listed below will be required to comply with these directives:

1. All Article 28 general hospitals, excluding those which have been designated as Financially Distressed Facilities pursuant to paragraph (c) of subdivision 19 of Section 2807-c of the Public Health Law, for cash operating receipts associated with all general hospital inpatient and ambulatory services, including services licensed under the Mental Hygiene Law, less any amounts received for personal needs allowances and refunds.

2. Article 28 Residential Health Care Facilities for cash operating receipts associated with all inpatient and adult day care services less any amounts received for personal needs allowances and refunds.

3. All Article 28 Diagnostic and Treatment Centers for cash receipts associated with health related and clinic services, excluding receipts from billed family planning units of service for facilities which possess a separate Medicaid Family Planning rate. For Diagnostic and Treatment Centers operated by a Health Maintenance Organization in accordance with Article 44 of the Public Health Law and Article 43 of the Insurance Law, cash receipts for services to HMO subscribers *shall not* be subject to the assessment.

4. All Article 36 Certified Home Health Agencies for cash operating receipts associated with all home care services.

5. All Article 36 Long Term Home Health Care Programs for cash operating receipts associated with all home care services, excluding waivered services identified as non-assessable in accompanying attachment regarding this program.

6. All Personal Care Service Providers, both licensed and exempt agencies, which possess a Title XIX (i.e., Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the Social Services Law, for cash operating receipts associated with the delivery of such service less receipts from Certified Home Health Agencies and Long Term Home Health Care Programs resulting from paraprofessional contract arrangements.

Attached are detailed instructions for each of the above referenced provider groups. These instructions should be followed carefully since they provide more explicitly directives on cash receipts which are affected by the assessment. Furthermore, for organizations which may fall in more than one of the provider groups referenced above, compliance with

instructions and resulting assessment payments *must be handled separately*.

Assessment payments for the applicable period are to be made on a *monthly basis*. Payments are due within *15 days* following each affected month. Consequently, providers are required to submit their first payment by *February 15, 1991* which will be calculated based on cash operating revenues received during the month of January 1991. Payments due for each subsequent month, through March 31, 1992, should be determined and submitted accordingly.

Monthly payment checks should be made to the payment of the *1991-92 Health Facility Assessment Fund* and mailed to:

Mr. Herbert Radeker
Assessment Fund Administrator
Blue Cross/Blue Shield of Central New York
344 South Warren Street
P.O. Box 4809
Syracuse, New York 13221

Each monthly payment should include an accounting summary indicating the actual basis for determining the facility's monthly assessment liability. As stated earlier, for organizations which fall in more than one of the above referenced provider groups *separate* payment checks and accounting summary's should be submitted for each applicable service category.

It should be noted that failure to comply with the directives outlined in this letter *will* result in the recoupment of your facility's estimated monthly assessment liability, along with interest and/or penalty, from various third party payments. Applicable statutory provisions (i.e., Section 2807-d(6)(8) and Section 3614-a(6)(8) of the Public Health Law; and Section 367-i(5)(7) of the Social Services Law) are summarized as follows:

1. If a monthly payment is not received within 15 days following the applicable assessment month, or if the

received payment is less than 70% of the State Commissioner of Health's estimate of the facility's monthly assessment liability, the unpaid balance increased by a 25% penalty will be recouped from the facility's Medicaid, Blue Cross and/or Health Maintenance Organization outstanding receipts.

2. If a monthly payment is determined to be less than 90% of the State Commissioner of Health's estimate of the facility's monthly assessment liability the balance due will be increased by a 12% interest charge which must be paid in the month proceeding notification of the balance due. If at least two previous monthly assessment payments within a six month period were determined to be less than 90% of such monthly estimates, the balance due increased by a 12% interest charge will be recouped from the facility's Medicaid, Blue Cross, and/or Health Maintenance Organization outstanding receipts.

The Commissioner of Health is required to provide a facility at least a three day notice of any estimated amount due along with the basis for calculating such amount, prior to its collection from the above stated third-party receipts. A facility may request a hearing to object to the estimates made by the Commissioner within 60 days of receipt of the notice on the amount due. The Commissioner is required to grant a hearing within 30 days of receipt of a facility's request for hearing or collection of the amount due.

Facilities will also be required to submit quarterly and *certified* annual reports on cash gross receipts for the affected months. The first report will be due on March 15, 1991 to reconcile cash gross receipts for January 1991. Thereafter, quarterly reports will be due within 45 days of the proceeding quarter to reconcile cash gross receipts for the previous quarter commencing with the January-March 1991 quarter. An annual *certified* cash gross receipts report will also be

required at the end of each affected annual period. Further instructions and required reporting forms will be supplied through a future transmittal.

Please read each applicable attached section carefully to determine the basis for establishing your facility's monthly assessment liability. Questions regarding this correspondence should be directed to the Bureau of Information Management and Analysis at (518) 474-1673.

Sincerely,

/s/ STEVEN C. ANDERMAN
Steven C. Anderman
Deputy Director
Division of Health Care Financing

ARTICLE 28 HOSPITAL
CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All hospitals licensed under Article 28 of the Public Health Law, excluding financially distressed hospitals as described in Paragraph (c) of Subdivision 19 Section 2807-c are assessed monthly a percentage of cash receipts from patient services and general operations.

Rate of Assessment

Facilities' assessment percentage, determined in accordance with the statute, is based upon the percentage of 1989 Medicaid inpatient revenues as a percentage of total 1989 inpatient revenues as reported on the 1989 Institutional Cost Report. The hospital rate of assessment schedule is as follows:

	Medicaid	0% to 10%	Assessment Rate	.5%
Hospital	"	10% to 15%	Assessment Rate	.525%
(Inpatient &	"	15% to 20%	Assessment Rate	.65%
Ambulatory	"	20%	Assessment Rate	.675%
services)				
Hospital-Based RHCF			Assessment Rate	.6%
Hospital-Based Certified Home Health Agencies			Assessment Rate	.6%
Hospital-Based Long Term Home Health Care Services			Assessment Rate	.6%
Hospital-Based Personal Care Services			Assessment Rate	.6%

If your Hospital does operate an RHCF, Certified Home Health Agency, Long Term Home Health Care Program, and/or Personal Care Service Program, you should also refer

to the applicable attachments regarding these programs and follow specified instructions accordingly.

Assessable Hospital Income

- ALL cash receipts from Patient Care Services less any amounts applicable to patient or third-party refunds, irrespective of payment source or service date, received during January 1, 1991 through March 31, 1992.
- Investment Income, except as otherwise referenced on this attachment, received during January 1, 1991–March 31, 1992.
- Other Operating Income, including:

  Non-Patient Food Sales
  Laundry and Linen Services Revenue
  Social Work Services Revenue
  Housing Revenue
  Parking Revenue
  Housekeeping Services Revenue
  Telephone and Telegraph Revenue
  Data Processing Services Revenue
  Purchasing Services Revenue
  Sale of Abstracts/Medical Records
  Sale of Scrap and Waste
  Cash Receipts from Externally Granted Rebates and Refunds
  Vending Machine Commissions
  Other Commissions
  Television/Radio Rentals
  Non-patient Room Rentals
  Management Services Revenue
  Other Operating Revenue not specifically referenced below as being non-assessable.
  Transfers from Restricted Funds for Other Operating Expenses
  Gift Shop Revenue

If unable to separately identify *Other Operating Income* amounts due to commingled funds or inadequate records which are applicable to hospital versus hospital-based RHCF, Certified Home Health, Long Term Home Health and Personal Care Service assessable cash receipts, then the hospital inpatient assessment percent shall apply.

Non-Assessable Income

- Patient Personal Fund Allowances
- Investment Income from:

  Externally Restricted Plant Funds (e.g. sinking funds, operating escrow. funded depreciation).

  Medical Malpractice Insurance Funds
- Distributions from Bad Debt and Charity Care Regional Pools
- Primary Health Care Services Regional Pools
- Bad Debt and Charity Care for Financially Distressed Hospitals Statewide Pools and Bad Debt and Charity Care and Capital Statewide Pools created under Section 2807-c
- All schools leading to licensure
- Income from grants, charitable contributions, donations and bequests and governmental deficit financing.
- Donated Commodities
- Sales and Excise Taxes

Assessment Percentage

Please refer to the attached computation of your facility's assessment percentage. Changes or corrections to data should be submitted as specified on the attached.

RESIDENTIAL HEALTH CARE FACILITIES CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All residential health care facilities, which includes all nursing facilities previously certified as HRF's or SNF's licensed under Article 28 of the Public Health Law, are assessed six-tenths (.60%) of one percent on monthly cash receipts from resident and nonresident services and general operations.

Assessable Residential Health Care Facility Cash Receipts

- All cash receipts from patient care services less any amounts applicable to patient or third-party refunds, irrespective of payment source or service date, received during January 1, 1991–March 31, 1992.
- Investment income, except as otherwise referenced in this attachment, received during January 1, 1991–March 31, 1992.
- Cash receipts for the above period from patient services and other operating income, which will be assessed include:

Resident Service Revenue—All Sources
Nonresident Service Revenue—All Sources
Cash Receipts Applicable to Prior Periods
Supplies and Services Sold to Others
Private Duty Nursing Fees
Cafeteria, Gift Shop and Public Restaurants
Rental Income from Real Property, Equipment and Other Telephone and Telegraph Services
Television and Radio Rentals
Vending Machine Commissions and Other Commissions
Medical Records and Abstract Fees
Sale of Scrap and Waste
Barber and Beauty Shops

Cash Receipts for Externally Granted Rebates and Refunds
Transfers from Restricted Funds for Other Operating Expenses
Income from Unrestricted Bank Accounts
Income from Unrestricted Investments
Extraordinary Income
All Other Cash Receipts not specifically referenced below as being non-assessable:

Non-Assessable Cash Receipts

Grants
Charitable Contributions
Donations
Bequests
Income from Funded Depreciation Accounts
Income from Operating Escrow Account
Income from Mortgage Repayment Escrow Accounts
Patient Personal Fund Allowances
Income Earned on Patient Personal Funds
Government Deficit Financing
Sale and Excise Taxes

Payment Mechanism

Estimated payments shall be forwarded to the Commissioner or his designee on a monthly basis and are due on or before the fifteenth (15th) day following the end of a calendar month to which the assessment applies. Payments made by nursing facilities previously dually certified as SNFs and HRFs should be combined for the two previous certified entities.

ARTICLE 28 DIAGNOSTIC AND TREATMENT CENTER CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All Diagnostic and Treatment Centers licensed under Article 28 of the Public Health Law are assessed a percentage on monthly cash receipts from patient services and general operations.

A facility's assessment percentage, determined in accordance with the statute, is based upon six-tenths of one percent of the facility's gross cash receipts received during the reporting period.

Assessable Diagnostic and Treatment Center Income

- All cash receipts from patient care services less amounts applicable to patient or third-party refunds, irrespective of payment source or service date, received during January 1, 1991–March 31, 1992;
- Investment Income, except as otherwise referenced in this attachment, received during January 1, 1991–March 31, 1992;
- Cash receipts from other operating income for the time period noted above which will be assessed include:

  Non-Patient Food Sales
  Social Work Services Revenue
  Housing Revenue
  Parking Revenue
  Housekeeping Services Revenue
  Gift Shop Revenue
  Revenues from Rental of Premises or Equipment
  Sale of Abstracts/Medical Records
  Sale of Scrap and Waste
  Cash Receipts from Externally Granted Rebates and Refunds
  Vending Machine Commissions
  Other Commissions

  Television/Radio Rentals
  Non-Patient Room Rentals
  Management Services Revenue
  Other Operating Revenue Not Specifically Referenced Below as Being Not Eligible For The Assessment
  Transfers from Restricted Funds for Other Operating Expenses

Non-Assessable Income

- Investment Income from Externally Restricted Plant Funds (Sinking Funds) and from funded depreciation.
- Distributions from Disproportionate Share Bad Debt/Charity Care Allowances to Primary Comprehensive Care Facilities
- Grants provided to County Sponsored Diagnostic and Treatment Centers as part of Local Public Health Aid financing
- Income received from grants, charitable contributions, donations, bequests, government deficit financing.
- Sales and Excise Taxes.

For Diagnostic and Treatment Centers operated by a health maintenance organization operating in accordance with Article 44 of the Public Health Law or Article 43 of the Insurance Law, receipts received for services to HMO subscribers *shall not* be subject to the assessment.

For those Diagnostic and Treatment Centers that have distinct Medicaid rates of payment for family planning services, the cash receipts from such services to Medicaid clients *shall not* be subject to the assessment.

CERTIFIED HOME HEALTH AGENCY
CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All Certified Home Health Agencies certified under Article 36 of the Public Health Law are assessed a percentage on monthly cash receipts from patient services and general operations.

An agency's assessment percentage, determined in accordance with the statute, is based upon six-tenths of one percent of the agency's gross cash receipts.

Assessable Certified Home Health Agency Income

- All cash receipts from patient care services less amounts applicable to patient or third-party refunds, irrespective of payor source or service date, received during January 1, 1991–March 31, 1992;
- Investment Income, except as otherwise referenced in this attachment, received during January 1, 1991–March 31, 1992;
- Cash receipts from other operating income for the time period noted above which will be assessed include:

  Social Work Services Revenue
  Patient Assessment and Case Management Revenue
  Parking Revenue
  Housing Revenue
  Housekeeping Service Revenue
  Gift Shop Revenue
  Non-Patient Food Sales
  Revenues from Rental of Premises or Equipment
  Sale of Abstracts/Medical Records
  Sale of Scrap and Waste
  Cash Receipts for Externally Granted Rebates and Refunds

  Vending Machine Commissions
  Other Commissions
  Other Operating Income Not Specifically Referenced Below as Being Not Eligible for the Assessment
  Transfers from Restricted Funds for Other Operating Expenses

Non-Assessable Income

- Investment Income from Externally Restricted Plant Funds (Sinking Funds) and from funded depreciation.
- Distributions from Disproportionate Share Bad Debt/Charity Care Allowances to Certified Home Health Agencies
- Income received from grants, charitable contributions, donations, bequests, and government deficit financing.
- Grants provided to Public Health Nursing Services as part of Local Public Health Aid financing.
- Sales and Excise Taxes.

For agencies that contract with a long term home health care program to provide patient care services to a LTHHCP patient, the cash receipts for such services *shall not* be subject to the assessment.

For those agencies that provide personal care services through contracts with a local Department of Social Services, please also refer to the Personal Care Service Providers Attachment.

LONG TERM HOME HEALTH CARE PROGRAM CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All Long Term Home Health Care Programs certified under Article 36 of the Public Health Law are assessed a percentage on monthly cash receipts from patient services and general operations.

An agency's assessment percentage, determined in accordance with the statute, is based upon six-tenths of one percent of the agency's gross cash receipts.

Accessible Long Term Home Health Care Program Income

- All cash receipts from patient care services (excluding the waivered services listed in the "Non-Assessable Income" section below) less amounts applicable to patient or third-party refunds, irrespective of payment source or service date, received during January 1, 1991–March 31, 1992;
- Investment Income, except as otherwise referenced in this attachment, received during January 1, 1991–March 31, 1992;
- Cash receipts from other operating income for the time period noted above which will be assessed include:

  Social Work Services Revenue
  Patient Assessment and Case Management Revenue
  Parking Revenue
  Housing Revenue
  Housekeeping Service Revenue
  Gift Shop Revenue
  Revenues from Rental of Premises or Equipment
  Sale of Abstracts/Medical Records
  Sale of Scrap and Waste

  Cash Receipts from Externally Granted Rebates and Refunds
  Vending Machine Commissions
  Other Commissions
  Other Operating Income Not Specifically Referenced Below as Being Not Eligible for the Assessment
  Transfers from Restricted Funds for Other Operating Expenses

Non-Assessable Income

- Income from the following waivered services:

  Social Day Care
  Social Transportation
  Congregate Meals
  Home Maintenance Tasks
  Housing Improvement
  Moving Assistance
  Respite Care
  Personal Emergency Response System

- Investment Income from *Externally* Restricted Plant Funds (Sinking Funds) and funded depreciation.
- Income received from grants, charitable contributions, donations, bequests, and government deficit financing.
- Grants provided to Public Health Nursing Services as part of Local Public Health Aid financing.
- Sales and Excise Taxes.

For those agencies that provide personal care services through contracts with a local Department of Social Services, please also refer to the Personal Care Service Providers Attachment.

PERSONAL CARE SERVICE PROVIDERS CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All Personal Care Service Providers, both licensed and exempt agencies, possessing a Title XIX (i.e., Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the Social Services Law will be required to pay to the State a .6% assessment on monthly cash receipts from January 1, 1991-March 31, 1992. The following will identify specific income sources which should be included and excluded from your agency's calculation of your monthly assessment liability.

Assessable Income

- All cash receipts from personal care services less amounts applicable to patient or third-party refunds, as defined by Section 367-i of the Social Services Law, irrespective of payment source or service date.
- All Investment and Rental Income earnings received by the corporate entity possessing the Personal Care Service contract with a Local Social Services District pursuant to Section 367-i of the Social Services Law.

Non-Assessable Income

- All cash receipts from patient care services, other than those defined above as personal care services, (e.g. nursing, therapies, home health aide, durable medical equipment, pharmaceuticals, etc.).
- All cash receipts from Certified Home Health Agencies and Long Term Home Health Care Programs received pursuant to paraprofessional contracts to supply personal care services to clients of such programs.

- Grants, charitable contributions, donations, bequests, and government deficit financing funds.
- Interest earned on capital funds which have been *externally* restricted for capital debt retirement purposes.
- Sales and Excise Taxes.

Payment Mechanism

Estimated payments, pursuant to the above, shall be forwarded to the Commissioner or his designee on a monthly basis and are due on or before the fifteenth (15th) day following the end of a calendar month to which the assessment applies.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

92 CIV. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

NOTICE OF MOTION

TO: ROBERT ABRAMS, Attorney General of the State of New York
JANE LAUER BAKER, Assistant Attorney General in Charge of Labor Bureau
RICHARD CORENTHAL, Assistant Attorney General
120 Broadway
New York, New York 10271
(212) 416-8711
Attorneys for Defendants

PLEASE TAKE NOTICE that in accordance with the briefing schedule established by the parties, plaintiffs will move this court pursuant to Fed. R. Civ. P. 56 for summary judgment

(A) adjudging that New York Public Health Law § 2807-d is null, void, and ineffective under the Supremacy Clause of Article VI of the Constitution of the United States because that state law is preempted by the Employee Retirement Income Security Act ("ERISA") to the extent that it assesses contributions or other payments for benefits provided by ERISA plans;

(B) enjoining defendants from administering and enforcing New York Public Health Law § 2807-d insofar as it requires plaintiffs to pay any assessments on contributions or other payments received by medical centers operated by them to provide healthcare benefits to ERISA plan beneficiaries; and

(C) granting restitution to plaintiffs in the amount of all preempted assessments previously paid together with lawful interest thereon.

This motion is based on the annexed Revised Rule 3(g) Statement, the annexed affidavit of Rubin D. Fier sworn to September 22, 1992, and exhibits thereto, the accompanying memorandum of law, and the pleadings and other proceedings heretofore had herein.

Dated: New York, New York
September 23, 1992

LAMBOS & GIARDINO

By: FRANCIS S. L'ABBATE
C. PETER LAMBOS (CL 0932)
FRANCIS S. L'ABBATE (FL 8545)
29 Broadway - 9th Floor
New York, New York 100006
(212) 943-2470

LAW OFFICE OF
THOMAS W. GLEASON

By: KEVIN MARRINAN
KEVIN MARRINAN (KM- 6450)
26 Broadway - 17th Floor
New York, New York 10004
(212) 425-3240

Co-Counsel to Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

REVISED STATEMENT OF UNDISPUTED MATERIAL FACTS

Plaintiffs, by and through their attorneys, Thomas W. Gleason and Lambos & Giardino, pursuant to Local Rule 3(g), submit this revised statement of undisputed material facts in support of a motion for summary judgment.

1. The NYSA-ILA Medical and Clinical Services Fund ("the Fund") provides medical, dental, and other healthcare services on an out-patient ambulatory basis to eligible employees, pensioners, and their dependents through three medical centers owned and operated by the Fund, two of which are located in the State of New York.

2. The Fund and its medical centers are a multiemployer employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act.

3. New York Public Health Law § 2807-d imposes an assessment on the cash receipts of the two New York medical centers operated by the Fund.

4. The cash receipts upon which the assessment is imposed consist of the following contributions or other payments for healthcare benefits provided to ERISA plan beneficiaries:

a) Man-hour contributions paid by non-longshore employers as required by their collective bargaining agreements;

b) Payments from the NYSA-PPGU Welfare Fund for medical and dental services rendered to its beneficiaries;

c) Worker compensation insurance payments for healthcare services provided to Fund beneficiaries;

d) Prescription charges paid by Fund beneficiaries; and

e) Annual registration fees paid by Fund beneficiaries.

5. Plaintiffs have paid $7,066.02 to defendants under protest, of which $6,953.47 represents assessments imposed on contributions or other payments for healthcare benefits provided to ERISA plan beneficiaries.

Dated: New York, New York
September 23, 1992

LAMBOS & GIARDINO

By: FRANCIS S. L'ABBATE
C. Peter Lambos (CL 0932)
Francis S. L'Abbate (FL 8545)
29 Broadway - 9th Floor
New York, New York 100006
(212) 943-2470

LAW OFFICE OF
THOMAS W. GLEASON

By: KEVIN MARRINAN
Kevin Marrinan (KM 6450)
26 Broadway - 17th Floor
New York, New York 10004
(212) 425-3240

Co-Counsel to Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

AFFIDAVIT

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

RUBIN D. FIER, being duly sworn, deposes and says:

1. I am the treasurer of the NYSA-ILA Medical and Clinical Services Fund (hereinafter "Fund"), which along with its trustees are the plaintiffs in this lawsuit. I make this affidavit in support of plaintiffs' motion for summary judgment invalidating on Employee Retirement Income Security Act (hereinafter "ERISA") preemption grounds the imposition by the State of New York of an assessment on certain contributions received by medical centers operated by the Fund to provide healthcare benefits to the Fund's participants and their dependents. I am intimately acquainted with the affairs of the Fund and its medical centers and have personal knowledge of the facts set forth in this affidavit.

Structure of the Fund

2. The Fund is a jointly administered, multiemployer, labor-management trust fund established in accordance with § 302(c)(5) of the Labor Management Relations Act, 29 U.S.C.A. § 186(c)(5) (West Supp. 1992), and pursuant to an Agreement and Declaration of Trust and Plan and collective bargaining agreements between the New York Shipping Association, Inc. ("NYSA") and the International Longshoremen's Association, AFL-CIO ("ILA"), prescribing the terms and conditions of longshore employment in the Port of New York and New Jersey. The Fund is a self-insured employee welfare benefit plan under ERISA § 3(1), 29 U.S.C.A. § 1002(1) (West Supp. 1992), that provides medical, dental and related healthcare services on an out-patient ambulatory basis to over 20,000 eligible beneficiaries consisting of plan participants and their dependents, including more than 13,000 in the State of New York.

3. There are four classes of persons receiving healthcare services from the Fund. The first and predominant class consists of longshore workers and retirees and their dependents, whose right to Fund benefits stems from longshore employment in the Port. The NYSA-ILA labor contract entitles these

individuals to receive healthcare at medical centers operated by the Fund in the states of New York and New Jersey. The second class is composed of warehouse and other workers represented by non-longshore ILA locals who are eligible for treatment at Fund medical centers under the terms of separate labor contracts with their employers, who for purposes of differentiating them from longshore employers are classified by the Fund as "outside employers." Private police responsible for cargo security at waterfront terminals in the Port comprise the third class of persons receiving healthcare services provided by the Fund. These waterfront security personnel are represented by the Port Police and Guards Union ("PPGU"). The fourth and final group of beneficiaries consists of local union officers and employees who are eligible to use the Fund's medical centers by virtue of their locals' agreements with the Fund.

4. The Fund provides healthcare benefits through medical centers that it owns and operates. Prior to 1992 the Fund operated four medical centers: two in New York and two in New Jersey. Only the two medical centers in New York—the Brooklyn center and the Manhattan center—are subject to the assessment challenged in this case. The Fund's medical centers are not open to the general public but are available only to those eligible to receive healthcare services from the Fund.

5. The Fund and its centers operate exclusively for nonprofit purposes and conduct no trade, business, or commercial activity of any kind. They are not subject to federal, state, or local income taxation. They are also exempt from the New York City General Corporation and Unincorporated Business Taxes, the New York City Commercial Rent or Occupancy Tax, and the New York City Real Property Tax.

6. The Fund is exempt from taxation pursuant to Section 501(c)(9) of the Internal Revenue Code as a voluntary employees' beneficiary association. Copies of the August 12, 1963, exemption letter and the July 18, 1979, letter advising

that the exemption letter continues in effect are attached to my affidavit as Exhibit 1.

7. The 501(c)(9) tax exempt status extends to both the Fund and its medical centers. The Fund's Return of Organization Exempt From Income Tax (IRS Form 990) includes the operations of both the Fund and the medical centers. A sample copy of this tax return for calendar year 1991 is attached to my affidavit as Exhibit 2.

8. The Fund also reports to the Internal Revenue Service and the United States Department of Labor, Pension and Welfare Benefits Administration, on Form 5500, since the Fund is covered by ERISA. The Fund's 5500 report includes the operations of both the Fund and its medical centers. A sample Form 5500 filed by the Fund for calendar year 1990 is attached to my affidavit as Exhibit 3.

Financing of the Fund

9. Employer contributions are the principal source of monies used to fund the healthcare benefits provided by the Fund. Some employer contributions are made to the Fund directly and are then funnelled to the centers. Other employer contributions are paid directly to the medical centers. Employers of longshore workers are obligated by the NYSA-ILA collective bargaining agreement to pay assessments that fund fringe benefits through an assessment imposed on cargo and containers transported through the Port. These assessments fund all employee fringe benefits for longshore workers, including pension benefits, welfare benefits, medical and clinical benefits, etc. The portion of the assessments that fund medical and clinical benefits is paid to the Fund on a weekly basis. The Fund then funnels an amount sufficient to meet the weekly expenses for each of the medical centers. The weekly amount transferred to the centers is based upon prior experience and is adjusted periodically to conform to current fiscal demands. Should the Fund transfer more than is needed

for a particular week, a lesser amount would be forwarded to the medical centers in later weeks.

10. A second source of employer contributions comes from various ILA local unions which pay to the Fund directly man-hour contributions on behalf of their officers and employees. These contributions in turn form part of the monies transferred weekly to the medical centers on an as-need basis.

11. Outside employers pay man-hour contributions for the medical and clinical benefits provided to their employees as required by the terms of their separate labor agreements. Since many of these outside employers operate single facilities, their employees are eligible to be treated only at the medical center nearest their workplace. Consequently, each outside employer has historically paid its contributions directly to the medical center at which its employees are eligible to be treated. Although the outside employers' contributions could be paid to the Fund itself, direct payment to the medical center simplifies what would otherwise be a cumbersome internal administrative problem of allocating these outside contributions to the appropriate medical centers.

12. Waterfront security guards in the Port are participants in their own ERISA welfare plan, the NYSA-PPGU Welfare Fund, which provides medical and clinical benefits for the guards and their dependents. Excessive costs forced the NYSA-PPGU Welfare Fund to close its own medical center in July 1988. At a later date it entered into a contractual arrangement with the Fund to allow port guards and their dependents to be treated at the medical centers operated by the Fund. The NYSA-PPGU Welfare Fund pays for medical and dental services rendered to its participants on a fee-for-service basis.

13. The final source of contributions, made only to the Brooklyn Medical Center, consists of receipts from workers' compensation insurance carriers. The Brooklyn Medical Center is authorized by N.Y. WORK. COMP. LAW § 13-c (3) (McKinney 1992) to service Fund participants who have been

injured on the job and are covered by workers' compensation insurance. The Brooklyn Medical Center bills the insurance carrier for the medical services it renders to participants, all of whom are eligible for treatment at the center. The workers' compensation payments received by the Brooklyn Center offset the costs of healthcare services which the Fund must provide and which would have had to be financed by contributions from the same employers paying for the workers' compensation coverage.

14. In light of the dramatic cost increases experienced in recent years, the Fund had to change its traditional method of being funded solely by employer contributions. The NYSA-ILA labor contract for the three year period from October 1, 1986, to September 30, 1989, inaugurated a new method of employee contributions. To help defray rising costs, the NYSA-ILA labor agreement imposed a prescription charge of $2.00 per prescription on each beneficiary to whom prescription drugs are dispensed at any medical center. This was the first time that any obligation for medical costs was placed directly upon the beneficiaries of the Fund. It produced revenue of approximately $1 million per annum.

15. Costs continued to escalate at an alarming rate. As a result, the 1990-1994 longshore labor contract imposed additional obligations on Fund participants. A $20 per-family, annual registration fee was inaugurated, and the prescription charge was increased to $5.00. Even these additional employee contributions were insufficient to meet the skyrocketing costs experienced by the Fund. Consequently, the Fund was forced to close one of its four medical centers. This defunct center was located in Hoboken, New Jersey.

Health Facility Assessment

16. Effective January 1, 1991, the State of New York enacted a Health Facility Assessment on the gross receipts from patient care services of general hospitals, residential healthcare facilities, and diagnostic and treatment centers.

The Fund's medical centers fell within the third category of facilities subject to the assessment. The assessment on the Fund's medical centers is now fixed at "six-tenths of one percent of each facility's gross receipts received from all patient care services and other operating income on a cash basis." N.Y. PUB. HEALTH LAW § 2807-d(2)(c) (McKinney Supp. 1992).

17. On January 24, 1991, the New York State Department of Health issued a letter to all hospitals and facilities subject to the assessment. A copy of this letter, which contained separately attached instructions for reporting and paying the assessment, is attached as Exhibit "A" to the June 11, 1992, affidavit of Richard Pellegrini, which was submitted by defendants in support of their motion for summary judgment. The instructions for Article 28 Diagnostic and Treatment Centers lists both assessable receipts and non-assessable receipts. The former includes cash receipts from patient care services, investment income, and cash receipts from certain enumerated categories of operating income, including sale of abstracts/medical records, sale of scrap and waste, and commissions. The latter includes "Income received from grants, charitable contributions, donations, bequests, government deficit financing."

18. The first health facility assessment reports submitted by the Fund on behalf of the Brooklyn and Manhattan medical centers covered the nine-month period ending September 30, 1991. Copies of these initial reports and the succeeding monthly reports for October and November 1991 are attached to this affidavit as Exhibit 4. Upon advice of co-counsel the Fund concluded that neither the statute nor the instructions imposed any assessment on monies transferred weekly by the Fund to the medical centers to meet their operating expenses. None of these transfers related to the furnishing of services for particular patient care or constituted income from the operations of the centers. These transfers were no more than the utilization of employer contributions to provide the

healthcare benefits furnished by the Fund through its medical centers. These weekly transfers of employer contributions are akin to grants and other types of non-assessable receipts. I did include on Item 1 of the report, which is entitled "Cash From Patient Care Services," the following revenue items received directly by the medical centers:

Outside Employer Contributions
NYSA-PPGU Welfare Fund Payments
Prescription Charges From Beneficiaries
Registration Fees From Participants
Payments From Workers' Compensation Carriers
Fees For Medical Examinations of Applicants For Disability Pensions

Under Item 5 of the report, which is entitled "Other Assessable Cash Receipts," both centers listed various miscellaneous items, including interest on the refund of payroll taxes, fees for reproducing medical records, and proceeds from the sale of scrap and waste.

19. For the period commencing on January 1, 1991, and ending on November 30, 1991, the Fund reported and paid assessments on the following:

Reported Item	Brooklyn Center	Manhattan Center	Total
Item 1			
Outside Employer Contributions	$199,573	—	$199,573
Prescription Charges	407,180	195,765	602,945
Registration Fees	112,640	55,364	168,004
Workers' Compensation Payments	51,255	—	51,255
NYSA-PPGU Welfare Fund Payments	78,456	56,878	135,334
Disability Pension Examinations	1,800	—	1,800

Reported Item	Brooklyn Center	Manhattan Center	Total
Item 5			
Medical Abstracts/Records	13,961	1,739	15,700
Sale of Scraps/Waste	227	21	248
Telephone Commissions	216	—	216
Supplier Rebates	1,119	—	1,119
Interest on Payroll Taxes	610	866	1,476
	$867,037	$310,633	$1,177,670

The total Health Facility Assessments paid by the Fund amounted to $7,066.02, consisting of $5,202.22 for the Brooklyn center and $1,863.80 for the Manhattan center.

20. On April 19, 1991, the Fund submitted a protest to the Department of Health of the State of New York challenging the imposition of the Health Facility Assessment on medical centers operated by an ERISA welfare plan. The protest, a copy of which is annexed to this affidavit as Exhibit 5, urges discontinuance of the assessment against the Fund and its medical centers because the assessment is preempted by ERISA. No response to the protest was forthcoming until December 20, 1991. In the interim, in order to avoid interest and penalties, the Fund filed the assessment reports attached hereto as Exhibit 4 for the eleven-month period ending November 30, 1991, and paid the applicable assessments for that period. By letter dated December 20, 1991, a copy of which is attached to this affidavit as Exhibit 6, the New York State Department of Health rejected the Fund's protest. The Fund then ceased payment of the assessment and commenced this action. The Fund discontinued the filing of assessment reports and began placing the amount of assessments that would have been paid in a separate escrow account.

21. The Fund has also restructured its payment procedures. Since early 1992 the registration fees and the payments from the NYSA-PPGU Welfare Fund are remitted to the Fund, not

to the medical centers. Although the Fund can redirect to the Fund all payments now received by the medical centers and thus effectively circumvent the Health Facilities Assessment, it has not done so pending the outcome of this litigation.

/s/ RUBIN D. FIER
RUBIN D. FIER

Sworn to before me this
22nd day of September, 1992

/s/ RAY TARONE
Notary Public

RAY TARONE
Notary Public, State of New York
No. 31-9484625
Qualified in New York County
Commission Expires Feb. 28, 1993

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR January 1, 1991 to Sept. 30, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF BROOKLYN, INC.

OPERATING CERTIFICATE NO. 7001205R

WHOLE DOLLARS ONLY

A	B	C	D	E
ASSESSABLE PROVIDER INCOME	CURRENT MONTH	PRIOR PERIOD ADJUSTMENT	ADJUSTED AMOUNT	YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 714,099	$ —	$ 714,099	$ 714,099
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 714,099	$	$ 714,099	$ 714,099
4. CASH RECEIVED FROM INVEST-MENTS	$	$	$	$
5. OTHER ASSESSABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	11,422		11,422	11,422
Sale of scrap & waste	177		177	177
NY telephone commissions	198		198	198
Interest—tax refunds	607		607	607
Rebates	1,119		1,119	1,119
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 13,523	$	$ 13,523	$ 13,523
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 727,622	$	$ 727,622	$ 727,622
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$4,365.73	
10. OTHER ADJUSTMENTS			$ —	
11. AMOUNT DUE			$4,365.73	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$	
13. TOTAL PAYMENTS YEAR-TO-DATE				$

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAY-MENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR THE MONTH ENDED October 31, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF BROOKLYN, INC.

OPERATING CERTIFICATE NO. 7001205R

WHOLE DOLLARS ONLY

A ASSESSABLE PROVIDER INCOME	B CURRENT MONTH	C PRIOR PERIOD ADJUSTMENT	D ADJUSTED AMOUNT	E YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 60,816	$	$ 60,816	$ 774,915
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 60,816	$	$ 60,816	$ 774,915
4. CASH RECEIVED FROM INVEST-MENTS	$ —	$	$	$ —
5. OTHER ASSESSABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	1,230		1,230	12,652
Sale of scrap & waste	—		—	177
NY telephone commissions	—		—	198
Interest—tax refunds	3		3	610
Rebates	—		—	1,119
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 1,233	$	$ 1,233	$ 14,756
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 62,049	$ —	$ 62,049	$ 789,671
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$ 372.24	
10. OTHER ADJUSTMENTS			$ —	
11. AMOUNT DUE			$ 372.24	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$ —	
13. TOTAL PAYMENTS YEAR-TO-DATE				$ 4,738.02

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAYMENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR THE MONTH ENDED November 30, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF BROOKLYN, INC.

OPERATING CERTIFICATE NO. 7001205R

WHOLE DOLLARS ONLY

A ASSESSABLE PROVIDER INCOME	B CURRENT MONTH	C PRIOR PERIOD ADJUSTMENT	D ADJUSTED AMOUNT	E YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 75,989	$	$ 75,989	$ 850,904
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 75,989	$	$ 75,989	$ 850,904
4. CASH RECEIVED FROM INVEST-MENTS	$	$	$	$
5. OTHER ASSESSABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	1,309		1,309	13,961
Sale of scrap & waste	50		50	227
NY telephone commissions	18		18	216
Interest—tax refunds	—		—	610
Rebates	—		—	1,119
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 1,377	$	$ 1,377	$ 16,133
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 77,366	$	$ 77,366	$ 867,037
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$ 464.20	
10. OTHER ADJUSTMENTS			$	
11. AMOUNT DUE			$ 464.20	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$ —	
13. TOTAL PAYMENTS YEAR-TO-DATE				$ 5,202.22

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAYMENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

NYSA-ILA MEDICAL CENTER OF NEW YORK

Detail of Line 1

Cash From Patient Care Services

	1-1-91 to 9-30-91	Oct. 1991	Nov. 1991	1-1-91 to 11-30-91
Pharmacy surcharge	154,732	17,520	23,513	195,765
Registration fee	54,640	304	420	55,364
PPGU recoveries	48,077	5,645	3,156	56,878
	257,449	23,469	27,089	308,007

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR January 1, 1991 to Sept. 30, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF NEW YORK

OPERATING CERTIFICATE NO. 7002221R

WHOLE DOLLARS ONLY

A ASSESSABLE PROVIDER INCOME	B CURRENT MONTH	C PRIOR PERIOD ADJUSTMENT	D ADJUSTED AMOUNT	E YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 257,449	$	$ 257,449	$ 257,449
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 257,449	$	$ 257,449	$ 257,449
4. CASH RECEIVED FROM INVEST-MENTS	$	$	$	$
5. OTHER ASSESSABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	1,135		1,135	1,135
Sale of scrap and waste	21		21	21
Interest—tax refunds	866		866	866
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 2,022	$	$ 2,022	$ 2,022
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 259,471	$	$ 259,471	$ 259,471
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$1,556.83	
10. OTHER ADJUSTMENTS			$	
11. AMOUNT DUE			$1,556.83	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$ —	
13. TOTAL PAYMENTS YEAR-TO-DATE				$

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAY-MENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR THE MONTH ENDED October 31, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF NEW YORK

OPERATING CERTIFICATE NO. 7002221R

WHOLE DOLLARS ONLY

A ASSESSABLE PROVIDER INCOME	B CURRENT MONTH	C PRIOR PERIOD ADJUSTMENT	D ADJUSTED AMOUNT	E YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 23,469	$ —	$ 23,469	$ 280,918
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 23,469	$ —	$ 23,469	$ 280,918
4. CASH RECEIVED FROM INVEST-MENTS	$	$	$	$
5. OTHER ASSESSABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	223		223	1,358
Sale of scrap and waste	—		—	21
Interest—tax refunds	—		—	866
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 223	$	$ 223	$ 2,245
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 23,692	$	$ 23,692	$ 283,163
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$ 142.15	
10. OTHER ADJUSTMENTS			$ —	
11. AMOUNT DUE			$ 142.15	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$	
13. TOTAL PAYMENTS YEAR-TO-DATE				$ 1,698.98

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAY-MENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR THE MONTH ENDED November 30, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF NEW YORK

OPERATING CERTIFICATE NO. 7002221R

WHOLE DOLLARS ONLY

A ASSESSABLE PROVIDER INCOME	B CURRENT MONTH	C PRIOR PERIOD ADJUSTMENT	D ADJUSTED AMOUNT	E YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 27,089	$ —	$ 27,089	$ 308,007
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 27,089	$ —	$ 27,089	$ 308,007
4. CASH RECEIVED FROM INVEST-MENTS	$	$	$	$
5. OTHER ASSESS ABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	381	—	381	1,739
Sale of scrap and waste	—		—	21
Interest—tax refunds	—		—	866
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 381		$ 381	$ 2,626
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 27,470	$	$ 27,470	$ 310,633
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$ 104.83	
10. OTHER ADJUSTMENTS			$ —	
11. AMOUNT DUE			$ 104.83	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$ —	
13. TOTAL PAYMENTS YEAR-TO-DATE				$[ILLEGIBLE]

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAYMENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

[LETTERHEAD OF NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND]

April 19, 1991

VIA FEDERAL EXPRESS

Steven C. Anderman,
Deputy Director
Division of Health Care Financing
State of New York
Department of Health
Corning Tower
The Governor Nelson A. Rockefeller
Empire State Plaza
Albany, New York 12237

Dear Mr. Anderman:

The undersigned are Co-Counsel to the NYSA-ILA Medical Center of Brooklyn, Inc. and the NYSA-ILA Medical Center of New York, Inc. ("the Medical Centers"), both of which are in receipt of your recent letter concerning the Health Facility Cash Receipt Assessment Program ("the Assessment"). The undersigned are also Co-Counsel to the NYSA-ILA Medical and Clinical Services Fund ("the Fund") which owns both Medical Centers.

This statement is submitted in support of the Medical Centers' position that they are not subject to the Assessment since they are not-for-profit tax exempt organizations and integral parts of an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"). Accordingly, the Assessment may not be levied on the plan since it is pre-empted by ERISA.

Background

The Medical Centers are not-for-profit corporations incorporated by special acts of the New York Legislature (Chapter 988, Laws of New York 1957, as amended by Chapter 818, Laws of New York 1958, Chapter 807, Laws of New York 1961 and Chapter 1013, Laws of New York 1974; Chapter 624, Laws of New York 1958, as amended by Chapter 758, Laws of New York 1961 and Chapter 594, Laws of New York 1963). The Medical Centers render out-patient, ambulatory medical, dental and related health care services to approximately 17,000 longshore workers employed in the Port of New York and New Jersey and their dependents and pensioners and their dependents. The Medical Centers do not operate independently of the Fund. The Fund owns the Medical Centers and the land on which they are located. More importantly, the Fund provides the monies necessary for their operation. (The Fund also owns and provides the monies necessary for the operation of the NYSA-ILA Medical Centers of Newark and Hoboken which treat approximately 13,000 longshore workers, pensioners and dependents.)

The Fund is a joint labor-management trust fund established pursuant to a collective bargaining agreement between the New York Shipping Association, Inc. ("NYSA") and the International Longshoremen's Association, AFL-CIO ("ILA"). A copy of the Memorandum of Settlement of the Port of Greater New York and New Jersey dated November 28, 1990 and effective December 1, 1990 through September 30, 1994 is submitted herewith as Exhibit 1. Provisions relating to the Fund and Medical Centers are on pages 3-5 and page 8.

The Fund is a Taft-Hartley Trust Fund under Section 302 of the Labor-Management Relations Act of 1949, 29 U.S.C. §186. It is also exempt from taxation pursuant to Section 501(c)(9) of the Internal Revenue Code as a voluntary employees' beneficiary association. Copies of the August 12, 1963 exemption letter and the July 18, 1979 letter advising that the exemption letter continues in effect are submitted

herewith as Exhibit 2. As noted previously the Fund is an employee welfare benefit plan as defined in ERISA. ERISA § 3(1), 29 U.S.C. § 1002(1).

The 501(c)(9) tax exempt status of the Fund encompasses the Medical Centers. The Fund's Return of Organization Exempt From Income Tax (Form 990) includes the operations of the Fund and the Medical Centers. A copy of the Fund's Form 990 for 1989 is submitted herewith as Exhibit 3.

As an ERISA Fund the Fund also reports to the Internal Revenue Service and Department of Labor on Form 5500, which also includes the operations of the Fund and the Medical Centers. A copy of the Fund's 1989 Form 5500 is submitted herewith as Exhibit 4.

As noted above, the Fund, through the Medical Centers, provides medical, dental and related health care services on an out-patient ambulatory basis to approximately 12,500 participants and their dependents eligible under the NYSA-ILA collective bargaining agreement. The beneficiaries do not pay for services rendered to them, except for a $20-per-family annual registration fee and a $5-per-prescription charge.*

The Fund and Medical Centers all operate exclusively for nonprofit purposes and conduct no trade, business or commercial activity of any kind.** They are not subject to federal, state or local income taxation. The Medical Centers are exempt from the New York City General Corporation and Unincorporated Business Taxes, the New York City Commercial Rent or Occupancy Tax, and the New York City Real Property Tax. Copies of the Medical Centers' December 3, 1990 Requests For Continuation of Real Property Tax Exemp-

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* The Medical Centers provide medical and dental services to eligible participants under the NYSA-PPGU Welfare Fund. That fund's participants are the waterfront security guards and their dependents. The NYSA-PPGU Welfare Fund pays for these services on a fee-for-service basis in accordance with a contract between the NYSA-PPGU Welfare Fund and the Fund on behalf of the Medical Centers.

** The Fund's Form 990 for 1989 (Exhibit 3) shows a negative fund balance of over 4 million dollars both at the beginning and end of the year.

tions, and the January 15, 1991 letters continuing the real property tax exemption as to three of the five lots owned by the Fund are submitted herewith as Exhibit 5. Official notification letters have not yet been received as to the other two lots although the Fund does not pay real property taxes on them.

The Medical Centers Are Not Subject To The Assessment Since They Are Tax Exempt, Integral Parts of An ERISA Employee Welfare Benefit Plan. Thus, The Assessment Is Pre-Empted By ERISA

Section 514 of ERISA, 29 U.S.C. § 1144, provides:

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * *

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the

extent it provides for more than the effective administration of such Act as in effect on such date.

* * *

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

* * *

* * *

Thus, state laws which relate to employee welfare benefit plans, including state tax laws, are expressly pre-empted by ERISA.

See Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41 (1987) (noting the "expansive sweep" of the pre-emption clause); *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983) (Congress used the words "related to" in § 514(a) in their broad sense); *Birdsong v. Olson*, 708 F.Supp. 792 (W.D. Texas 1989) ("Congress has expressly indicated that state tax laws related to employee welfare benefit plans are preempted"); *Northwest Airlines, Inc., et al. v. Roemer, et al.*, 603 F.Supp. 7 (D. Minnesota 1984) ("In 1983, when ERISA's preemption language was amended to exclude Hawaii's experimental health benefit statute from § 1144(a), Congress specifically endorsed the preemption of state tax laws."); *National Carriers' Conference Committee, et al. v. Heffernan*, 454 F.Supp. 914 (D. Connecticut 1978) (because of the potential use of

taxation as a means of regulation, preempting state taxation of ERISA-covered plans is necessary to effectuate Congressional objectives).

Accordingly, to apply the Assessment to the Medical Centers would be in violation of the pre-emption provisions of ERISA and the cases decided thereunder.

Conclusion

The State of New York is pre-empted by ERISA from applying the Assessment to the NYSA-ILA Medical Center of Brooklyn, Inc. and the NYSA-ILA Medical Center of New York, Inc.

If you require any further information, please contact the undersigned.

Very truly yours,

LAMBOS & GIARDINO

By: RICHARD P. LERNER
Richard P. Lerner

THOMAS W. GLEASON

By: ANDRE MAZZOLA
Andre Mazzola

Co-Counsel

Enclosures 2790 mb

cc: Board of Trustees
NYSA-ILA Medical and Clinical Services Fund

Board of Directors
NYSA-ILA Medical Centers of New York and Brooklyn, Inc.

No. 95-1594

(8)

Supreme Court, U.S.
FILED
NOV 20 1996
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

—against—

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS

BARBARA G. BILLET
Solicitor General

PETER H. SCHIFF
Deputy Solicitor General

DANIEL F. DE VITA
Assistant Attorney General
in Charge of Labor Bureau

M. PATRICIA SMITH*
Assistant Attorney General

* *Counsel of Record*

DENNIS C. VACCO
Attorney General of the
State of New York
Attorney for Petitioners
120 Broadway
New York, New York 10271
(212) 416-8707

34 pp

QUESTION PRESENTED

Whether section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a) (1994), preempts New York Public Health Law § 2807-d (McKinney 1993), which imposes a tax of six-tenths of one percent on the operating income of all hospitals in New York State, to the extent that the tax is applied to the income of medical centers owned and operated by an ERISA fund.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

No. 95-1594

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

—against—

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at 74 F.3d 28 (2d Cir. 1996) and

reproduced at JA 6.[1] The order of the Supreme Court granting a writ of certiorari, vacating the judgment and remanding the case to the Second Circuit is reported at 115 S. Ct. 1819 (1995) and is reproduced at 5a. The initial opinion of the Second Circuit is reported at 27 F.3d 823 (2d Cir. 1994) and is reproduced at JA 10. The memorandum opinion and order of the United States District Court for the Southern District of New York (Martin, J.) is not reported and is reproduced at 15a to 23a.

JURISDICTION

This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1) (1994). The judgment of the court of appeals was entered on January 4, 1996. A petition for a writ of certiorari was timely filed on April 3, 1996.

STATUTES INVOLVED

The pertinent statutes, section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a) and N.Y. Pub. Health Law §§ 2801(1), 2807-d(1)(a), 2807-d(2)(c) (McKinney 1993), are reproduced in the appendix to the petition for a writ of certiorari at 27a to 28a.

STATEMENT OF THE CASE

This case questions the extent to which ERISA preemption insulates ERISA-covered welfare benefit plans from traditional areas of state regulation when plans choose to operate in those areas. New York regulates all providers of hospital care services without regard to whether a provider is owned

[1] References to the joint appendix filed with this Court are cited as (JA ___). References to the appendix attached to the petition for writ of certiorari are cited as (_a).

by an ERISA plan. If a plan chooses to operate its own medical center, instead of purchasing services from others, the State's regulation falls upon plan-owned facilities.

In this case, the ERISA plan has argued, and the Second Circuit has agreed, that a generally applicable tax imposed upon all hospitals in New York cannot be imposed on plan-owned facilities simply because they are plan-owned. States must be able to regulate the activities in which ERISA plans choose to engage so long as that regulation does not impermissibly intrude upon those plan functions which ERISA preemption is intended to protect, that is, plan administration and plan benefit structure. Any other result would confer upon ERISA plans a charmed existence which Congress did not intend.

A. The Hospital Assessment

In 1990, in order to offset increased health care costs and as an alternative to substantial Medicaid payment reductions which would otherwise have been required (JA 42-43, 50), the New York State Legislature enacted section 2807-d of the New York Public Health Law, referred to by the courts below as the Health Facility Assessment or "HFA." 1990 N.Y. Laws, ch. 938.[2] The HFA, with certain exceptions not relevant here, is imposed upon all "hospitals" in New York. Hospitals are defined to encompass any facility engaged in providing services under the supervision of a physician or dentist, including diagnostic centers and treatment centers. N.Y. Pub. Health Law § 2801(1) (McKinney 1993).

The HFA is assessed at six-tenths of one percent for diagnostic and treatment centers. Assessable income is defined to include all gross receipts from: (1) patient care services irrespective of payment source; (2) investment income; and (3)

[2] The assessment, as originally enacted, was to expire on April 1, 1992, but was amended to remain in effect after that date. 1995 N.Y. Laws, ch. 2, § 135.

other operating income, such as non-patient food sales, parking revenues, medical records fees, and the like (JA 60-61). N.Y. Pub. Health Law §§ 2807-d(1)(a), 2807-d(2)(c) (McKinney 1993). Hospitals are required to submit quarterly reports of gross receipts subject to the tax. N.Y. Pub. Health Law § 2807-d(7)(d) (McKinney 1993). Assessments are to be forwarded monthly and eventually become part of the State's general fund (JA 48-49).

Respondents are trustees of the NYSA-ILA Medical and Clinical Services Fund (the "Fund"). The Fund is a labor-management trust governed by Section 302 of the Labor-Management Relations Act of 1947, 29 U.S.C. § 186. It was established pursuant to collective bargaining agreements between the New York Shipping Association, Inc. ("NYSA") and the International Longshoremen's Association ("ILA") (JA 20-21). The Fund administers a self-insured, ERISA covered, multi-employer welfare benefit plan ("NYSA plan"). *See* 29 U.S.C. § 1002 (1).

The Fund owns and operates two medical centers in New York and one in New Jersey which deliver medical, dental, and other health care services on an outpatient basis (JA 21). The New York medical centers are incorporated separately as New York not-for-profit corporations and are licensed by the New York State Department of Health as "diagnostic and treatment centers" pursuant to N.Y. Pub. Health Law § 2805 (McKinney 1993)(JA 98). The centers deliver medical services principally to NYSA employed longshore workers, retirees, and dependents (JA 75-76). The centers also deliver medical services to ILA members employed by non-longshore employers ("outside employers") (JA 76). Finally, the centers deliver medical services to members of another union, the Port Police and Guards Union ("PPGU"), pursuant to a contract between the PPGU's ERISA plan and the Fund (JA 75-76, 78).

The medical centers' income is derived from a number of sources. NYSA employer contributions are remitted to the Fund which in turn transfers them to the medical centers as needed. Outside employer contributions are remitted directly to the medical centers. Fee-for-service payments are made directly to the medical centers by the PPGU fund and from workers' compensation carriers. Employee registration fees and co-payments for services are made to the centers. Finally, there are miscellaneous sources, such as supplier rebates and medical records fees (JA 77-79, 81-82).

The medical centers filed reports and paid the hospital assessment for the period from January 1, 1991 through November 30, 1991 (JA 81-82, 84-96). The centers did not report as assessable income any monies transferred from the Fund, treating such income as a grant which is non-assessable income under state law (JA 80-81). The State did not contest that exclusion. The centers reported as assessable income outside employer contributions to the centers, fee-for-service payments from the PPGU fund and workers' compensation carriers, employee payments for certain services, as well as miscellaneous income (JA 80-81). For the period January 1, 1991 through November 30, 1991, the centers reported assessable income of $1,177,670 and paid assessments totaling $7,066.02 (JA 81-82). Thereafter, the centers discontinued filing reports and paid no further assessments (JA 82).

B. Prior Proceedings

On April 16, 1992, the Fund commenced this action against the New York State Commissioner of Health and other Health Department officials (referred to collectively as the "State") for declaratory and injunctive relief and for a refund of the assessments already paid on the ground that the hospital assessment is preempted by ERISA to the extent it "imposes a levy on contributions and payments for health care benefits provided by the Fund" (9a). The parties cross-moved for summary judgment pursuant to Fed. R. Civ. P. 56.

In an opinion dated February 18, 1993, the district court granted the State's motion, determining that the hospital assessment is not preempted by ERISA. The court reasoned that the HFA is a law of general application applying to all health facilities with only an incidental economic impact on ERISA plans (21a).[3] The court concluded that the tax "does not interfere with calculation of benefits" or with the "determination of an employee's eligibility for benefits" (21a). Pointing to the *de minimis* amount of the assessment, the court distinguished this case from *The Travelers Insurance Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y.), *aff'd*, 14 F.3d 708 (2d Cir. 1993), *rev'd sub nom. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, ___ U.S. ___, 115 S. Ct. 1671 (1995), in which three New York State surcharges imposed on hospital bills of varying amounts of 9%, 11%, and 13%, depending on the identity of the third-party payor, were invalidated by the Second Circuit as ERISA-preempted (22a).

On June 23, 1994, the Second Circuit reversed the district court. The court rejected the district court's conclusion that the HFA was a law of general applicability. The court stated that because "the HFA targets only the health care industry" which is, "by definition, the realm where ERISA welfare plans must operate, [the assessment] was bound to affect them" (12a). Because the Fund had chosen to provide medical benefits through its own medical centers, the court concluded that the HFA operated as an immediate tax on payments and contributions which were intended to pay for medical benefits (JA 16).

Relying on its decision in *The Travelers Insurance Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1993), *rev'd sub nom. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, ___ U.S. ___, 115 S. Ct. 1671 (1995), the Second Circuit held that the assessment "relates to" the Fund directly by reducing assets otherwise available to provide health care benefits, thereby causing the Fund to reduce benefits provided or charge more to its beneficiaries (JA 16-17). According to the court, the impact of the assessment "will detrimentally affect the central mission and purpose of the Fund and hence cannot be characterized as remote and tenuous" (JA 16). Addressing the Fund's statement that it could avoid the tax altogether by funnelling all medical center income through the Fund, the court held that "such a restructuring would alter the Fund's established method of administration" and would in itself be a basis for ERISA preemption (JA 17).

[3] The district court did not reach the other issues raised by the State, namely that the Tax Injunction Act, 28 U.S.C. § 1341 (1994), barred the complaint and that the claim for a refund is barred by the Eleventh Amendment to the United States Constitution.

The State filed a petition for a writ of certiorari on October 21, 1994, after this Court granted the State's request for an extension of time within which to file the petition (26a). On May 1, 1995, this Court granted the petition, vacated the judgment, and remanded the case for further consideration in light of its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, ___ U.S. ___, 115 S. Ct. 1671 (1995) ("*Travelers*") (5a).

On January 4, 1996, the Second Circuit issued a decision adhering to its initial determination that the HFA was preempted by ERISA insofar as it applies to the income of a medical center owned by an ERISA fund. The court noted that in *Travelers*, the impact of the surcharges on ERISA plans was indirect because the surcharges were imposed not on "ERISA plans themselves, but on insurance carriers providing health insurance coverage to plans and their beneficiaries" (JA 8). The court held that this Court's decision in *Travelers* did not control because, unlike *Travelers*, "there is no third party between the plan and the tax imposed pursuant to the HFA," and the statute therefore "depletes the Fund's assets directly" (JA 9). The court concluded that "[n]othing in *Travelers* undermines our reliance on the HFA's direct economic

impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of pre-emption" (JA 9).

SUMMARY OF ARGUMENT

The HFA is a tax of general applicability imposed upon providers of hospital care. Whether characterized as direct or indirect, its effect on a plan's cost of doing business neither dictates nor restricts plan benefit structures nor plan administration. It, therefore, does not relate to a plan even when imposed upon plan-owned medical centers.

In *Travelers*, 115 S. Ct. at 1679, this Court held that state laws of general applicability in areas of traditional state regulation do not relate to plans, even if they have an economic impact upon plan choices, so long as they do not dictate or restrict plan benefit structure or plan administration. In *Travelers*, the Court held that the surcharges were not preempted, even though they affected the cost of benefits and the relative costs of competing insurance to provide them, because they did not bind plan choice. The HFA, even as applied to plan-owned medical centers, does no more. The HFA affects the cost of medical care and plans must use additional assets to cover the increased costs. This type of economic impact upon plans does not, however, relate to plans.

Travelers involved hospital surcharges on medical bills paid by insurers and HMOs which indirectly increased plan costs. The HFA, in this case, is imposed "directly" upon plan-owned medical centers. That difference is not a legally significant distinction. This Court has never relied upon the directness or indirectness of a law's impact upon plans as a determinative factor in preemption analysis. Thus, in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), this Court held a garnishment law of general applicability did not relate to plans, despite its direct imposition of

legal obligations upon plans. On the other hand, laws do not escape preemption simply because they bear indirectly upon plans. *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990). Instead, this Court has examined the nature of the impact upon plans in determining whether a law relates to plans.

The HFA is also not preempted as applied to plan-owned medical centers because operation of a medical facility is not a plan function which ERISA preemption was designed to protect. Employee benefit plans operate and are subject to state laws in many capacities other than as plans. They are employers, property owners, purchasers of goods and services and in some cases providers of medical care, day care and prepaid legal services. States may regulate plans as they engage in these activities so long as that regulation does not mandate or restrict the plan functions ERISA preemption was designed to protect.

ERISA preemption protects the plan functions of plan administration and benefit structure. The operation of a medical center is not one of these plan functions protected by ERISA preemption. It does not involve the type of plan administrative activities that this Court identified in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987). The Fund's ownership of the medical centers is not a plan benefit structure. The benefit provided by the plan is health care coverage. The benefit has been structured to provide coverage only for the health services available at certain centers. However, ownership of the medical centers is irrelevant to the benefit's structure. Both the NYSA plan, and another unrelated plan, the PPGU plan, have been similarily structured to limit coverage to the medical centers owned by the NYSA Fund. That one Fund owns the centers and the other does not, is incidental to the benefit structure of both plans.

The State is not precluded, in any event, from regulating the centers. Regulation of the plan-owned centers relates, at most, to the benefit provided by the plan, not the plan itself.

In *Fort Halifax*, 482 U.S. at 11, this Court held that laws that related to benefits, but not to plans, were not preempted by ERISA. While that case involved regulation of a benefit where no plan was involved, the Court's reasoning applies equally where a benefit is provided by a plan. States may regulate benefits so long as that regulation does not impermissibly intrude upon the structure or administration of the plan that provides the benefit.

ARGUMENT

THE HEALTH FACILITY ASSESSMENT DOES NOT "RELATE TO" ERISA PLANS BECAUSE IT IS A LAW OF GENERAL APPLICABILITY WHICH DOES NOT DIRECTLY OR INDIRECTLY MANDATE AN EMPLOYEE BENEFIT PLAN'S STRUCTURE OR ADMINISTRATION

Congress enacted ERISA as a "comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). However, ERISA's protection of participants in employee benefit plans extends only to the administration of plans. ERISA does not require the provision of benefits, nor does it substantively regulate any of the benefits which may be provided by plans. *Travelers*, 115 S. Ct. at 1674.

ERISA preempts laws that "relate to any employee benefit plan." 29 U.S.C. § 1144(a). While this preemption provision is broad, it does not alter the basic presumption in any preemption analysis that Congress does not intend to supplant state law. *See Maryland v. Louisiana*, 451 U.S. 725, 746 (1981). Moreover, where a State is acting in a field of traditional state regulation, "the historical police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest intent of Congress." *Travelers*, 115 S. Ct. at 1676 (citing *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Whether characterized as direct or indirect, the economic impact of a law of general applicability that does not control plan administration or benefit structure is irrelevant to preemption analysis. The HFA is a provider tax of general applicability designed to achieve a policy objective in an area of traditional state regulation, health care.[4] The law's effect on

[4] At least twenty other States utilize similar kinds of provider taxes to finance health care initiatives. *See* Ala. Code § 40-26B-21 (1995) (imposing "providers of medical services privilege tax" on nursing facilities); Conn. Gen. Stat. § 12-263(b), as amended by Pub. Act 96-144 (West, WESTLAW through 1996 Reg. Sess.) (tax on "hospital gross earnings of each hospital"); Fla. Stat. Ann. § 395.7015 (West 1995) (imposing 1.5% assessment on annual net operating revenues of certain "health care entities"); Haw. Rev. Stat. § 346E-2 (1995) (taxes of 6% and 4% imposed on "nursing facility income" and "hospital income" respectively); Ill. Ann. Stat. § 5/5A-2 (Smith-Hurd 1993 & Supp. 1995) (assessment of 1.88% of "adjusted gross hospital revenue" of "each hospital provider"); Ky. Rev. Stat. Ann. § 142.303 (Banks-Baldwin 1995) (2.5% tax on gross revenues of providers "for the provision of hospital services"); Me. Rev. Stat. Ann. tit. 22, § 391 (West 1992 & Supp. 1995) (assessment of .15% of hospital's "gross patient service revenues"); Mass. Ann. Laws ch. 118 F, § 15 (Law. Co-op. 1994 & Supp. 1996) (hospital assessments); Minn. Stat. § 256.9657 (West, WESTLAW through 1996 Reg. Sess.) (assessment on hospital revenues, nursing home beds and HMOs); Miss. Code Ann. § 43-13-145 (WESTLAW through 1995 Reg. Sess.) (assessment on nursing homes of two dollars per bed per day); Mo. Rev. Stat. § 208.453 (West, WESTLAW through 1995 1st Reg. Sess.) (hospitals pay "federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care"); Mont. Code Ann. § 15-60-102 (1995) ($2.80 "utilization fee" paid by each "nursing facility" for "each bed day in the facility"); N.H. Rev. Stat. Ann. § 84-A:2 (1991 & Supp. 1995) (tax "at a rate to be established by the legislature each biennium upon the gross patient services revenue of every hospital"); R.I. Gen. Laws § 44-51-3 (Michie, WESTLAW through 1995 Reg. Sess.) (assessment of 3.75% on "gross patient revenue received by every nursing facility"); S.C. Code Ann. § 12-23-810 (Law. Co-op. Supp. 1995) (hospital tax based on total expenditures of each hospital as a percentage of total hospital expenditures state-wide); Tenn. Code Ann. § 68-11-216(d) (WESTLAW through 1996 2d Reg. Sess.) (annual nursing

a plan's cost of doing business, whether characterized as direct or indirect, neither restricts nor dictates plan benefit structure or plan administration. With only a "tenuous, remote or peripheral connection" to plans, the HFA does not relate to plans so as to trigger preemption. *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 130 n.1 (1992) (citing *Shaw*, 463 U.S. at 100 n.21).

A. The HFA Does Not Relate to Plans Because It Has Only an Economic Impact upon Plans Which Does Not Restrict Plan Choice

In *Travelers*, this Court recognized that it was required to "go beyond the unhelpful text" of ERISA's preemption provision and "look instead to the objectives of the ERISA statute as a guide to the scope of state law that Congress understood would survive." 115 S. Ct. at 1677. Construing ERISA's preemption provision in light of its objective, "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," 115 S. Ct. at 1677-78, this Court held that state laws relate to plans and are preempted when they mandate "employee benefit structures or their administration." 115 S. Ct. at 1678.

This Court found that the challenged surcharges in *Travelers*, which made Blue Cross a more attractive insurance alternative, only had "an indirect economic effect on choices made by insurance buyers, including ERISA plans." 115 S. Ct. at 1679. Such economic influence "does not bind plan administrators to any particular choice and thus function as a

home tax); Utah Code Ann. § 26-36-105 (1995) (Medicaid Hospital Provider Temporary Assessment imposed on hospitals "audited gross patient revenues"); Vt. Stat. Ann. tit. 33, §§ 1950-58 (Supp. 1996) (4.02% "hospital assessment" imposed on each hospital's "audited gross inpatient revenues"); W. Va. Code §§ 11-27-9, 11-27-15 (1995) (health care providers tax of 2.5% of gross receipts on providers of "inpatient hospital services" and "outpatient hospital services"); Wis. Stat. § 50.14 (West Supp. 1995) (assessment on "occupied, licensed beds" of nursing home facilities).

regulation of the ERISA plan itself." 115 S. Ct. at 1679. ERISA therefore does not preempt state laws that have an impact "on the costs of benefits and the relative costs of competing insurance to provide them" so long as they do not otherwise preclude uniform administration of plans on an interstate basis. 115 S. Ct. at 1679. This Court also noted that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." 115 S. Ct. at 1680.

The reasoning of *Travelers* does not yield a different result in this case simply because the tax is applied to a hospital that an ERISA plan chooses to own and operate. The HFA is imposed upon all "hospitals" regardless of a hospital's relationship to ERISA plans. Like the surcharges at issue in *Travelers*, the HFA is a generally applicable statute that operates in an area of traditional state regulation. The HFA is neither specifically designed to apply to ERISA plans nor does it refer to ERISA plans. *See Greater Washington Board of Trade*, 506 U.S. at 130. Indeed, it "functions irrespective of the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139.

In *Travelers*, this Court's principal concern was whether the economic impact of the surcharges upon plans mandated a particular plan benefit structure or plan administration. In *Travelers*, this Court held that the surcharges were not preempted even though they affected the cost of benefits and the relative costs of competing insurance to provide them. The HFA, as it is applied to ERISA plan-owned medical centers, does no more than the surcharges in *Travelers*; it affects the costs of benefits.

In this case, only the preemption of the tax would have an economic impact on plan choices. Since the tax is imposed on all hospitals in New York, plans which do not own medical centers pay the tax as a portion of the charges they pay for

medical services delivered by other hospitals. If preempted, plans which own hospitals will be able to avoid the HFA and then operate at less expense.

Like the surcharges at issue in *Travelers*, the HFA increases the cost of hospital care throughout the State. The increased costs created by both laws are ultimately borne by plans which must use additional plan assets to cover the costs. Yet, this Court in *Travelers* held that this type of economic impact is not sufficiently related to plans to trigger preemption. 115 S. Ct. at 1679, 1681.

B. The Second Circuit Erred in Basing Its Analysis on the Directness, Rather Than the Nature, of a Law's Impact Upon Plans

The Second Circuit's decision on remand rests solely on the court's characterization of the HFA as having a "direct" impact upon the Fund. In the court's view, the impact of the HFA is direct because "there is no third party between the plan and the tax" (JA 9). This Court has never based its preemption analysis upon whether a law affects plans directly or through the regulation of another entity.

Nothing in *Travelers* supports the conclusion that a law which increases costs to plans "indirectly" through its application to third parties, such as that held not to be preempted in *Travelers*, is transformed into a preempted law when applied to a plan that happens to own or operate the third party. Indeed, the HFA is very similar to the 9% assessment upheld in *Travelers*, which is imposed upon the in-patient hospital costs paid by health maintenance organizations ("HMOs"). Under the Second Circuit's rationale, the 9% would be preempted if an HMO was owned by an ERISA plan. None of the reasons articulated by this Court for finding that the 9% assessment is not preempted is affected merely because a plan chooses to own an HMO, instead of purchasing HMO memberships.

Nor has this Court ever construed ERISA as preempting all laws that "directly" operate upon plans. In *Mackey*, the Court upheld a Georgia garnishment statute that operated directly upon plans. There was no third party between the law's obligations and the plan. Yet, this Court held that the administrative burdens and costs resulting from the direct application of the statute to plans were not enough to trigger preemption. 486 U.S. at 831. In *Mackey*, this Court also noted that run-of-the-mill state lawsuits against ERISA plans for unpaid rent, failure to pay creditors, and torts committed by plans were not preempted by ERISA. 486 U.S. at 833. The legal obligations at issue in such lawsuits also are felt directly by ERISA plans. On the other hand, this Court has held that laws do not escape preemption simply because they affect plans indirectly through another entity. *Ingersoll-Rand*, 498 U.S. at 139 (laws which depend upon the existence of ERISA plans are preempted even though their effect upon plans is indirect).

This Court instead has examined the nature of the law's effect upon the plan in determining whether the law relates to the plan. In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), the laws at issue were applied directly to plans. They dictated plan structure, therefore they related to the plans. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985), this Court found that the mandated benefit law at issue "bears indirectly" on plans since it regulated the content of insurance policies which are sold by insurance companies to plans. Nevertheless, since it dictated plan benefit structure by requiring mental health coverage, the law related to plans. In *Travelers*, the impact of the surcharges was similarly indirect inasmuch as the law regulated hospitals and not plans. However, this Court held that the law imposing those surcharges was not preempted, since the law did not bind plan choices. Thus, whether a law's impact upon ERISA plans is labeled direct or indirect is not a legally determinative distinction.

C. The HFA Is Not Preempted Because It Is Imposed upon the Fund In Its Capacity as a Provider of Medical Services, Not as a Plan

The HFA is not preempted for the additional reason that the operation of a medical center is not a plan function that ERISA preemption was designed to protect. The Fund pays the HFA as part of its operation of the medical centers. The Fund operates the medical centers not as a plan, but as a provider of medical services. The State may regulate this activity so long as the regulation does not mandate or restrict the plan functions, administration, and benefit structures, which ERISA preemption was designed to protect.

The NYSA plan provides the benefit of health care coverage. This benefit is structured to cover services provided at particular medical centers. Regulation of the centers, as hospitals, does not mandate or restrict the plan's choice of that benefit structure. It therefore cannot be said to relate to the plan. Even if the benefit is defined as the provision of medical services as opposed to health care coverage, preemption is not implicated. States may regulate employee benefits provided in-kind so long as that regulation does not mandate or restrict a plan's administration, or the structure of the benefits it provides. Therefore, a state tax on hospital income does not relate to a plan even when the entity that operates the hospital also administers an ERISA plan whose participants receive medical services at the hospital.

1. ERISA preemption only protects the plan functions of plan administration and benefit structure and does not extend to other activities in which plans engage

The purpose of ERISA preemption is to permit "nationally uniform administration of employee benefit plans." *Travelers*, 115 S. Ct. at 1678; *see also FMC Corp.*, 498 U.S. at 59-60; *Ingersoll-Rand*, 498 U.S. at 142; *Fort Halifax*, 482 U.S. at 10;

Shaw, 463 U.S. at 105. Accordingly, state laws that mandate plan benefit structures or plan administration relate to plans. *Travelers*, 115 S. Ct. at 1679. However, the provision of medical services is not within the scope of these plan functions which ERISA preemption is designed to protect, even when the services are provided by a plan-owned facility.

This Court has held that state laws that require plans to structure themselves in a certain manner relate to plans. Thus, in *Alessi*, 451 U.S. 524-25, a state law that prohibited plans from using a particular method to calculate pension benefits related to plans. In *FMC Corp.*, 498 U.S. at 60, an anti-subrogation statute, which prevented plans from being structured so as to require reimbursement from a third party in the event of recovery, related to plans. In *Metropolitan Life*, 471 U.S. at 735, and *Shaw*, 463 U.S. at 96, laws that would require plans to structure themselves to provide certain benefits, mental health coverage and pregnancy disability respectively, were held to relate to plans.

In *Fort Halifax*, 428 U.S. 1, 9, this Court discussed the scope of plan administrative practices that Congress intended to protect in enacting section 514(a):

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.

Thus, ERISA protects from state regulation the administrative practices in which plans must engage in order to pro-

vide benefits. However, not every activity in which a plan engages has that purpose and is protected by ERISA pre-emption. For example, in *Mackey*, 486 U.S. at 834, this Court held that the burden of the administrative practices necessarily engaged in by plans in order to comply with a general garnishment law did not trigger preemption.

Plans engage in many activities that are not plan functions. Plans purchase supplies, own or lease property, enter into contracts with banks, accountants, and attorneys, and act as employers of their own employees. Since ERISA does not preempt state laws that do not relate to plan functions, States may require plans to pay real estate, sales, and unemployment taxes and may require plans to comply with state contract and employment law. Similarily, the "run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan," *Mackey*, 486 U.S. at 834, do not relate to plans because they do not affect a plan in its capacity as a plan. When plans engage in non-plan activities, they may be regulated by the State to the same extent as any other commercial entity.

The distinction between plan functions and plans acting in other capacities is reflected in the statute and in this Court's decisions. ERISA explicitly allows a single entity to perform plan and non-plan functions. It permits, for example, employers to act both as plan sponsors, free from ERISA's fiduciary duties, and plan administrators, subject to them. *See* 29 U.S.C. § 1108(c)(3). ERISA also provides, as this Court has recognized, that any entity, whether an employer or not, that performs plan and non-plan administration functions is subject to ERISA only when it performs plan functions. *See* 29 U.S.C. § 1002(21)(A) (a person is an ERISA fiduciary only to the extent that he or she exercises any discretionary authority over plan administration or plan assets). Thus, in *Curtiss-Wright Corp. v. Schoonejongen*, ____ U.S. ____, 115 S. Ct. 1223, 1228 (1995), this Court noted that an employer who is also a plan administrator is not subject to ERISA's fiduciary

duties when adopting, amending or terminating a plan because these are not acts of plan administration.[5] In *Varity Corp v. Howe*, ____ U.S. ____, 116 S. Ct. 1065, 1071 (1996), in order to determine if fiduciary duties were implicated, this Court was required to determine whether a corporate employer was acting in its capacity as a plan administrator or in its capacity as an employer when it made certain misrepresentations to its employees. While *Varity* and *Curtiss-Wright* concerned an employer who also administers a plan, the need to distinguish plan activities from non-plan activities is equally present where, as in this case, a trust fund has been set up to administer a plan.

2. Plan operation of a hospital does not implicate plan administration

In this case, preemption analysis focuses on the distinction between plan functions and other activities in which a plan may engage. The Fund must perform certain administrative functions in order for the plan to operate. Those include determining participant eligibility, determining eligibility to be treated at a particular facility,[6] determining the amount and monitoring the availability of funds necessary to operate the facilities, determining how the funds will be made available to the facilities, assuring the availability of these funds, sending required notices, and keeping necessary records. These are the type of plan administrative functions which ERISA preemption protects from state regulation.

The Fund also acts in other, non-plan capacities. Although these other functions are performed by the Fund they are separate and distinct from the plan functions that ERISA pre-

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[5] Although a plan sponsor is not subject to ERISA's fiduciary duties when it acts to create, amend, or terminate a plan, those are plan benefit structure decisions, state regulation of which will relate to plans.

[6] Certain participants are eligible to be treated at only one of the medical centers (JA 78).

emption is designed to protect. Inasmuch as the Fund operates the medical facilities, it must also, *inter alia*, obtain the necessary licenses, purchase and maintain necessary medical equipment, hire necessary personnel, assure the proper credentialing of the medical personnel, comply with the State's quality control standards, devise and implement procedures for disposing of medical waste and for regular maintenance and sterilization of medical equipment and pay the tax at issue in this case. When the Fund operates in its capacity as a provider of medical services, it is subject to state laws that regulate such providers. The Fund also operates as an employer and, as such, is subject to state regulation of employers. Indeed, in *Shaw*, this Court recognized that while state anti-discrimination laws were preempted as applied to plans when they required plans to pay specific benefits, they were unaffected insofar as they prohibited discrimination in hiring, firing and promotion. 463 U.S. at 98 n.17.

In addition to operating medical facilities, plans may provide in-house day care centers. In that case, state laws that impose licensing fees or regulate staffing requirements, safety requirements, and sanitary requirements for day care centers are imposed directly upon plan operated centers. However, these requirements are imposed upon a plan as a day care provider and do not relate to the administration of the plan. Moreover, procedures designed to comply with these requirements are not the type of claims processing procedures which ERISA preemption is designed to protect. The same is true of prepaid legal services plans. ERISA may preempt the regulation of prepaid legal services plans *qua* plans, but does not reach the regulation of lawyers who render legal services under the plans.[7]

[7] As noted by the New York Court of Appeals soon after ERISA was passed, the State's interest in regulating prepaid legal services plans is to "assess the authenticity of the plan, to assure its freedom from any taint of improper professional conduct, to preserve the attorney-client relation, to require full disclosure to prevent fraud or other wrong upon the public, and, above all, to make sure that future professional conduct on behalf of the applicant organizations remains subject to the disciplinary control of the Appellate Division." *Matter of Feinstein (Attorney General)*, 36 N.Y.2d 199, 205, 326 N.E.2d 288, 291 (1976).

The distinction between plan functions and other activities in which plans engage is also important because it is increasingly common for plan sponsors to contract with managed care organizations such as HMOs which function as providers of care, in addition to providing many plan administrative functions. Self-insured plans may engage third parties to administer plans. As a result, these third parties may engage in plan activities such as processing claims and making benefit determinations. However, they also are themselves business enterprises. A State must be able to regulate the non-plan related activities in which these businesses engage. *See Metropolitan Life*, 471 U.S. at 741 (the regulation of an insurer or the way it sells insurance does not relate to plans, even though regulation of the contents of the insurance policy sold by insurers to plans relates to them since it mandates plans' benefit structures).

3. State regulation of a fund-owned hospital does not implicate plan benefit structures

In this case, the HFA is imposed upon the Fund in its capacity as a provider of medical care. Coverage for hospital care is one of the benefits which ERISA contemplates that plans may provide "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Even so, the State may regulate ERISA plan-owned hospitals because the ownership of the hospital is not part of the plan's benefit structure.

The benefit provided by the NYSA plan in this case is health care coverage. The plan assumes the obligation for the payment of certain health care services that are provided to plan participants. This benefit, health care coverage, is the same regardless of whether a plan provides it by self-insuring, purchasing HMO memberships, purchasing traditional indem-

nity insurance, or providing services in-kind. The NYSA plan's benefit has been structured to provide coverage only for the health care services available at certain medical centers. The decision to limit health care coverage to particular facilities is a benefit structure decision. It is similar to the decision, for example, to exclude from coverage mental health services, or to limit coverage to medical services arranged through certain HMOs. State regulation of that type of benefit structure decision relates to plans. *See Metropolitan Life*, 471 U.S. at 739.

However, the fact that the NYSA Fund happens to own the centers is incidental to the plan's benefit structure. Both the NYSA plan and another unrelated plan, the PPGU plan, are similarly structured to provide coverage for the services available at the same medical centers. The PPGU plan does not own the centers, and the NYSA Fund does. Nonetheless, each has the same benefit structure. State regulation does not affect the NYSA plan any differently than it does the PPGU plan, although the NYSA Fund happens to own the centers. In both cases, state hospital regulation affects the cost of operating the centers which, in turn, affects the cost of the coverage.

Traditional state regulation of the medical centers does not affect the plan's ability to structure its benefit uniformly across state lines. The NYSA Fund operates medical centers in both New York and New Jersey. Differing state regulation of hospitals may require the Fund, as a medical services provider, to administer its hospitals somewhat differently. However, the ability of the plan to structure its benefit by limiting coverage to certain medical centers is not affected.

4. A State may regulate an employee benefit to the extent that such regulation does not relate to a plan

The State is not precluded, in any event, from regulating the centers as hospitals. Regulation of the fund-owned medical centers relates, at most, to the benefit provided by the plan, not to the plan itself.

Most ERISA benefits are strictly financial. The plan pays money to a participant or a beneficiary in the event of some contingency such as retirement or death. A few welfare benefits, such as health care coverage, involve payment for services. ERISA contemplates that plans may provide coverage of certain welfare benefits by delivering services in-kind. Thus, plans may operate medical centers, day care centers, and prepaid legal plans, instead of providing coverage by paying for services rendered by others. *See* 29 U.S.C. § 1002(1). The decision to deliver certain services in-kind, however, does not transform the benefit provided by the plan into the plan to provide the benefit.

ERISA defines a welfare benefit plan as follows:

> any plan, fund, or program which was heretofore . . . established . . . to the extent that such plan, fund, or program was established . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services . . . .

29 U.S.C. § 1002(1).

The structure of the statute indicates that the benefits provided by plans are distinct from the plan to provide them. A "plan, fund, or program" is "established or maintained for the

purpose of providing" the specified benefits. Benefits, in turn, are what plans provide. Moreover, throughout ERISA the words "plan" and "benefit" are used separately and are not treated as equivalents. *Fort Halifax*, 482 U.S. at 8.

ERISA neither requires the provision of benefits nor establishes any minimum participation, vesting, or funding requirements for welfare benefits. Instead, "[i]n enacting ERISA, Congress's primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989). ERISA seeks to assure that an employee's expectation of benefits is not defeated by poor plan administration. *Id.* at 112. Thus, ERISA is concerned with the administrative structure established to provide the benefits, not the benefits themselves.

In *Fort Halifax*, 482 U.S. at 7, this Court relied on this distinction between "benefits" which an employer may provide and an "employee benefit plan" in holding that a Maine statute which required employers to make a one-time severance payment in the event of a plant closing, was not preempted. While the law mandated an employee benefit, it did not relate to a plan because compliance with the law did not require the on-going administrative practices which define a plan. Thus, this Court held that laws that relate to benefits, but not to plans, are not preempted by ERISA. *Id.* at 11. While *Fort Halifax* involved the regulation of a benefit where no plan was involved, the Court's reasoning applies equally to situations where the benefit is provided by a plan. Therefore, a State may regulate one of the benefits enumerated in ERISA even when a benefit is provided through a plan, so long as the regulation of the benefit does not impermissibly intrude upon the structure or the administration of the plan that provides benefits.

In fact, while ERISA's legislative history addressing the scope of preemption is limited, it contains guidance on pre-

cisely this issue. Senator Javits, a sponsor of ERISA, explained that while ERISA would preempt the "form and content" of a prepaid legal service plan, it would *not* preempt state regulation of the attorneys who provide the legal services. 3 Subcommittee on Labor of the Committee on Labor and Public Welfare, 93d Cong., 2d Sess., Legislative History of the Employee Retirement Income Security Act of 1974, at 4789-90 (Comm. Print 1976).

States have traditionally regulated medical care, day care, legal services and apprenticeship, the types of benefits that ERISA contemplates plans may provide by delivering services in-kind. Whether it is the tax in this case or more substantive regulation, such as quality control standards, the only impact that state regulation of these benefits has on plans is possibly to increase the cost of structuring the benefit as delivery of in-kind services. This economic effect is insufficient to result in preemption. *Travelers*, 115 S. Ct. at 1683.

CONCLUSION

For the reasons set forth, the Court should reverse the judgment below.

Dated: New York, New York
November 29, 1996

Respectfully submitted,

DENNIS C. VACCO
Attorney General of the
State of New York
Attorney for Petitioners
120 Broadway
New York, New York 10271
(212) 416-8707

BARBARA G. BILLET
Solicitor General

PETER H. SCHIFF
Deputy Solicitor General

DANIEL F. DE VITA
Assistant Attorney General
in Charge of Labor Bureau

M. PATRICIA SMITH*
Assistant Attorney General

* *Counsel of Record*

No. 95-1594

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS and PETER VICKERS,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR RESPONDENTS

THOMAS W. GLEASON
ERNEST L. MATHEWS, JR.*
GLEASON & MATHEWS, P.C.
26 Broadway, 17th Floor
New York, New York 10004
(212) 425-3240

C. PETER LAMBOS
DONATO CARUSO*
LAMBOS & JUNGE
29 Broadway, 9th Floor
New York, New York 10006
(212) 943-2470

Co-Counsel to Respondents
*(*Counsel of Record)*

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45 pp

QUESTION PRESENTED

The overbreadth of the question as framed by both petitioners and the United States overstates respondents' pre-emption challenge and misses the point of the decision of the court of appeals. Respondents do not claim and the court of appeals did not find that the New York statute is pre-empted as it applies to all income received by medical centers operated by ERISA plans but only when it taxes "payments and contributions which were intended to pay for participants' medical benefits" (App. 9). The correct formulation of the question, therefore, is as follows:

> Whether a state tax on the "gross receipts received from all patient care services and other operating income" of hospitals licensed to operate in the State, insofar as it directly applies to payments and contributions for healthcare benefits furnished to plan participants and their beneficiaries by medical centers owned and operated by ERISA plans, "relate[s] to" those plans within the meaning of ERISA Section 514(a), 29 U.S.C. 1144(a) (1994), and is thus preempted?

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ABBREVIATIONS

The following abbreviations will be used in this brief:

Joint Appendix	App.
Appendix to Petition for Certiorari	Pet. App.
Appendix in the Court of Appeals	C.A. App.
Brief for Petitioners	PB
Brief for the United States As *Amicus Curiae* Supporting Petitioners	SG
Brief of *Amicus Curiae* Healthcare Association of New York State And American Hospital Association In Support of Petitioners	HA
Brief For The States of Connecticut, *Et Al.*, As *Amici Curiae* In Support of Petitioners	AG
Brief of The National Governors' Association, Council of State Governments, National Conference of State Legislatures, National League of Cities, U.S. Conference of Mayors, National Association of Counties, And International City/County Management Associations As *Amici Curiae* In Support of Petitioners	NGA
Brief *Amicus Curiae* of The National Employment Lawyers Association In Support of Petitioners	NELA

Brief of The American Federation of State, County And Municipal Employees, AFL-CIO As *Amicus Curiae* In Support of Petitioners AFSCME

RULE 29.6 STATEMENT

In accordance with Sup. Ct. R. 29.6, respondents state that none of them has a corporate parent, subsidiary, or affiliate.

No. 95-1594

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Supreme Court of the United States

OCTOBER TERM, 1996

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BRIEF FOR RESPONDENTS

INTRODUCTION

In 1974 Congress enacted the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1461 (1994), a comprehensive regime to protect the interests of employees and their beneficiaries in private employee benefit plans. ERISA's "crowning achievement" was the elimination

of state regulation of ERISA plans. *Shaw v. Delta Air Lines,* 463 U.S. 85, 99 (1983). The issue in this case is whether ERISA's express pre-emption clause is to be dethroned and the states let loose to tax ERISA plans.

STATEMENT OF THE CASE

Structure of the Fund

Respondent NYSA-ILA Medical and Clinical Services Fund (the "Fund") is a jointly administered, multiemployer, labor-management trust fund established in accordance with § 302(c)(5) of the Labor Management Relations Act, 29 U.S.C. § 186(c)(5) (1994), and pursuant to an Agreement and Declaration of Trust and Plan and collective bargaining agreements adopted by the New York Shipping Association, Inc. ("NYSA") and the International Longshoremen's Association, AFL-CIO ("ILA") (App. 75). NYSA is the multiemployer collective bargaining representative for employers of longshore workers in the Port of New York and New Jersey (the "Port"), and ILA is a labor organization representing those employees. Both organizations negotiate and administer labor contracts prescribing the terms and conditions of longshore employment in the Port. Both appoint the individual trustees that manage the Fund.[1] Both established the Fund through collective bargaining to create and administer an ERISA-regulated employee welfare benefit plan that provides medical, dental, and other healthcare benefits on an outpatient, ambulatory basis to over 20,000 eligible beneficiaries consisting of ERISA plan participants and their dependents (App. 75).

Four classes of persons receive healthcare benefits from the Fund. The first and predominant class consists of longshore workers and retirees and their dependents, whose right to Fund benefits stems from longshore employment in the Port under NYSA-ILA labor contracts. The second class is

[1] The individual respondents were the trustees of the Fund in 1992, when this case arose.

composed of warehouse and other off-pier workers represented by non-longshore ILA locals who are eligible for treatment at Fund medical centers under the terms of separate labor contracts with their employers, who for purposes of differentiating them from longshore employers are classified by the Fund as "outside employers." Private police responsible for cargo security at waterfront terminals in the Port comprise the third class of persons receiving healthcare benefits provided by the Fund. These waterfront security personnel are represented by the Port Police and Guards Union ("PPGU"), and the terms and conditions of their employment in the Port are established by collective bargaining agreements negotiated by the PPGU with NYSA. The fourth and final group of beneficiaries consists of local union officers and employees who are eligible to use the Fund's medical centers by virtue of their locals' agreements with the Fund (App. 75-76).

The Fund provides healthcare benefits through medical centers that it owns and operates. Prior to 1992 the Fund operated four medical centers: two in New York and two in New Jersey (App. 76). One of the New Jersey centers was closed in 1992 (App. 79). None of these centers is open to the general public; access to treatment is limited to ERISA plan participants and beneficiaries (App. 76). The Fund and its centers operate exclusively for non-profit purposes, conduct no commercial activity of any kind, and are not subject to any federal, state, or local income taxation.[2] They are also exempt from local business, commercial rent, and real property taxes (App. 76).

[2] The Fund and its centers are exempt from taxation pursuant to section 501(c)(9) of the Internal Revenue Code, 26 U.S.C. § 501(c)(9) (1994), as a voluntary employees' beneficiary association (App. 76-77; C.A. App. 87-88). Annual filings with the Internal Revenue Service and the United States Department of Labor report the operations and financial activities of the Fund and its medical centers as a single, consolidated entity (C.A. App. 89-133).

Financing of the Fund

The healthcare benefits provided by the Fund through its medical centers are funded for the most part by employer and employee contributions that are prescribed in collective bargaining agreements. The medical centers' operating budgets, which total more than $19 million annually (C.A. App. 90, 97), are financed almost entirely from these contributions. Some employer contributions are made to the Fund directly and are then funneled by the Fund to the centers to pay their operating expenses. Other employer contributions are paid directly to the medical centers (App. 77).

Employers of longshore workers are obligated by the NYSA-ILA collective bargaining agreement to pay contributions that fund fringe benefits through an assessment imposed on cargo and containers transported through the Port. These assessments fund all employee fringe benefits for longshore workers, including pension, welfare, and medical and clinical benefits. The portion of the assessments that fund medical and clinical benefits is paid to the Fund on a weekly basis. The Fund then transfers to each center an amount sufficient to meet its weekly expenses (App. 77).

A second source of employer contributions comes from various ILA local unions which pay to the Fund directly man-hour contributions on behalf of their officers and employees. These contributions in turn form part of the monies transferred weekly to the medical centers on an as-need basis (App. 78).

Outside employers pay man-hour contributions for the medical and clinical benefits provided to their employees, who are eligible to be treated only at the medical center nearest their workplace. Each outside employer has historically paid its contributions directly to the medical center where its employees are treated (App. 78).

Waterfront security guards in the Port are participants in their own ERISA welfare plan, the NYSA-PPGU Welfare Fund, which provides medical and clinical benefits for the

guards and their dependents. Excessive costs forced the NYSA-PPGU Welfare Fund to close its own medical center in 1988. It entered into a contractual arrangement with the Fund to allow port guards and their dependents to be treated at the medical centers operated by the Fund. The NYSA-PPGU Welfare Fund pays for medical and dental services rendered to its participants on a fee-for-service basis (App. 78).

The final source of contributions, made only to the Fund's medical center in Brooklyn, New York, consists of receipts from workers' compensation insurance carriers. The Brooklyn Medical Center is authorized by N.Y. WORK. COMP. LAW § 13-c(3) (McKinney 1992) to treat Fund participants who have been injured on the job and are covered by workers' compensation insurance. The center bills the insurance carrier for the medical services it provides to plan participants, all of whom are eligible for treatment at the center. These workers' compensation payments offset the costs of healthcare benefits which the Fund must provide and which would have had to be financed by contributions from the same employers paying for the workers' compensation coverage (App. 78-79).

In light of dramatic cost increases experienced in recent years, the Fund had to change its traditional method of being funded solely by employer contributions. In 1986 the NYSA-ILA labor contract inaugurated a new method of employee contributions. To help defray rising costs, the labor contract imposed a prescription charge of $2.00 per prescription on each beneficiary to whom prescription drugs are dispensed at any medical center. This was the first time that any obligation for medical benefits was placed directly upon the beneficiaries of the Fund. It produced revenue of approximately $1 million per annum (App. 79; C.A. App. 105).

Costs continued to escalate at an alarming rate. As a result, in 1990 the longshore labor contract imposed additional obligations on Fund participants. A $20 per-family annual registration fee was instituted, and the prescription charge was increased to $5.00. Even these additional employee

contributions were insufficient to meet the sky-rocketing costs experienced by the Fund. Consequently, in 1992 the Fund was forced to close its Hoboken, New Jersey medical center (App. 79).

Health Facility Assessment

In 1991 the State of New York enacted a revenue-raising measure to replenish deficits in the State's general treasury caused principally by losses experienced by the State's Medicaid program (App. 32, 43, 48). The legislation imposed a Health Facility Assessment ("HFA") upon the receipts of general hospitals, residential healthcare facilities, and diagnostic and treatment centers. N.Y. PUB. HEALTH LAW § 2807-d (McKinney 1993 & Supp. 1996). The reach of this tax ensnared the medical centers operated by the Fund, which fell within the third category of facilities subject to the HFA (App. 80). *See* N.Y. PUB. HEALTH LAW §§ 2801(1), 2807-d(1)(a), 2807-d(2)(c) (McKinney 1993).

The HFA tax on diagnostic and treatment centers is now fixed at "six-tenths of one percent of each facility's gross receipts received from all patient care services and other operating income on a cash basis." N.Y. PUB. HEALTH LAW § 2807-d(2)(c) (McKinney 1993). Taxable receipts include monies received from patient care services, from investment income, and from certain enumerated categories of operating income, including parking lot revenues, gift shop sales, fees for reproducing medical records, proceeds from the sale of scrap and waste, and sales rebates and commissions (App. 60-61). *See* N.Y. PUB. HEALTH LAW §§ 2807-d(3)(c), 2807-d(3)(d) (McKinney 1993). Grants, charitable contributions, donations, bequests, and government deficit financing are exempt from the tax (App. 61). *See* N.Y. PUB. HEALTH LAW § 2807-d(3)(d) (McKinney 1993). Revenues raised by the HFA are paid into the general fund of the State of New York (App. 29, 48). *See* N.Y. PUB. HEALTH LAW § 2807-d(9) (McKinney 1993 & Supp. 1996).

Fund's ERISA Challenge

The Fund filed reports and paid the HFA for the first eleven months of 1991 (App. 80-82, 84-96; C.A. App. 134-41). The Fund excluded from taxable receipts the more than $19 million it disburses to the medical centers to pay their operating expenses. None of these remittances relate to the furnishing of services for particular patient care or constitute income from the operations of the centers. These transfers are no more than the utilization of employer contributions to provide the healthcare benefits furnished by the Fund. These weekly transfers of employer contributions are akin to grants that are nontaxable under New York law. *See* N.Y. PUB. HEALTH LAW § 2807-d(3)(d) (McKinney 1993). While the State has not yet contested the exclusion from the tax of Fund remittances to the centers, *see* PB at 5; SG at 4 n.3, any future change in the State's position could expose the Fund to HFA tax liabilities of about $120,000 per year.

The Fund does not contest the HFA in its entirety, only its application to contributions or other payments for healthcare benefits provided by the Fund through its medical centers. Consequently, the Fund does not challenge imposition of the HFA on miscellaneous revenue earned by the medical centers for activities that are unrelated to the healthcare benefits provided to plan participants and beneficiaries. This miscellaneous income includes proceeds from the sale of waste or scrap, fees for reproducing medical records, and supplier rebates and commissions (App. 82).

The Fund's ERISA pre-emption challenge in this case is limited to New York's attempt to assess two categories of receipts paid directly to the Fund's medical centers:

1) Contributions to fund the healthcare benefits provided by the Fund; and

2) Payments made for benefits provided to ERISA plan participants and their beneficiaries.

The first category involves amounts mandated by the terms of applicable collective bargaining agreements for the funding

of the healthcare benefits provided by the Fund (App. 78). This category includes both employer and employee contributions that are required to be paid whether or not the beneficiaries for whom the payments are made ever receive healthcare benefits from the Fund's medical centers. The employer contributions consist entirely of man-hour contributions from non-longshore, outside employers (App. 78); the employee contributions consist of prescription charges and annual registration fees imposed on plan beneficiaries through the collective bargaining process to help defray the rising healthcare costs encountered by the Fund (App. 79).[3]

The second category encompasses payments received directly by the Fund's medical centers for benefits provided. It includes payments from the NYSA-PPGU welfare plan for healthcare benefits provided to its beneficiaries and payments received from workers' compensation insurance carriers for healthcare benefits provided to Fund participants injured on the job (App. 78-79).

The receipts in both categories, which totalled about $1.16 million for the first eleven months of 1991, were received directly by the medical centers and were included in the HFA reports as taxable amounts for which the Fund paid the HFA tax of about $7,000 (App. 80-82). The Fund has since restructured its payment procedures. Since early 1992 the registration fees and the payments from the NYSA-PPGU Welfare Fund have been remitted to the Fund, not to the medical centers (App. 82-83).

The Fund protested the HFA on ERISA pre-emption grounds (App. 82, 97-102). When the State of New York denied the protest (C.A. App. 147-48), the Fund ceased payment of the tax and commenced this lawsuit both for a declaratory judgment that ERISA pre-empts the HFA to the extent that it

[3] The prescription charges are payable only when a beneficiary actually fills a prescription at a medical center. Hence, these charges could be classified in the second category, since they are paid only when benefits are received.

taxes contributions and other payments for healthcare benefits provided by ERISA plans and for restitution of the pre-empted taxes already collected from the Fund (App. 23, 82).[4]

Decision of District Court

On cross motions for summary judgment, the district court concluded that ERISA does not pre-empt the HFA (Pet. App. 16a, 19a, 22a).[5] The district court's pre-emption analysis was deceptively simplistic. While candidly admitting that the HFA leaves less money for benefits (Pet. App. 12a), the district court considered the rate of tax not large enough to pose a "serious economic threat" to ERISA plans (Pet. App. 21a). While acknowledging that there are no numerical standards prescribed in the law to determine just how much tax is too much, the district court's own subjective barometer sensed that the HFA's 0.6% rate "is not significant enough to warrant pre-emption of a state's traditional taxing power without explicit instructions from Congress" (Pet. App. 22a).

Decisions of Court of Appeals

The court of appeals reversed (App. 10-18). It rejected the proposition advanced by the district court, "that a regulation which has a *de minimis* economic impact on ERISA plans may withstand preemption regardless of what plan operations it affects" (App. 18). In the opinion of the court of appeals, whatever the magnitude of the exaction, "an immediate tax on payments and contributions which were intended to pay for participants' medical benefits" is pre-empted by ERISA because it "'relates to' the Fund and does so in a very direct way" (App. 16). "It does not touch the Fund only slightly on

[4] The petitioners, defendants below, are the New York officials responsible for the enforcement of the HFA. For ease of reference they will be referred to in this brief as the "State."

[5] The district court did not have to decide the legal sufficiency of the State's defense under the Tax Injunction Act, 28 U.S.C. § 1341 (1994) (Pet. App. 19a), and never reached the State's Eleventh Amendment defense.

the outer limits of its plan activities; it affects the very operations and functions that make the Fund what it is, a provider of medical, surgical, and hospital care to its participants and their beneficiaries" (App. 16).

The first petition for certiorari in this case was filed a few months before the decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995). When this Court remanded the case for further consideration in light of its *Travelers* decision, *see Chassin v. NYSA-ILA Medical & Clinical Serv. Fund*, 115 S. Ct. 1819 (1995), the court of appeals concluded that *Travelers* does not disturb "the ground upon which our earlier decision in this case rested" (App. 8). In the view of the court of appeals, the facts in this case distinguish it from *Travelers* because, as was found in its earlier determination, the HFA imposes "an immediate tax on payments and contributions which were intended to pay for participants' medical benefits . . . [and] thus directly affects the Fund in its principal role as an employee welfare benefit plan" (App. 9). This type of "direct economic impact on ERISA plans" is sufficient for a finding of ERISA pre-emption (App. 9).

SUMMARY OF ARGUMENT

There are certain connections between state laws and ERISA plans that are so clear and unmistakable that no prolonged and complicated analysis is necessary to conclude that these laws relate to the plans and so are pre-empted by ERISA. A state law that directly taxes contributions and other payments for healthcare benefits provided by ERISA plans falls within that category. To deny that the tax relates is to defy reality.

The careful analysis, as prescribed by this Court in *Travelers,* of Congressional will by reference to the objectives of ERISA, its legislative history, and the language of its pre-emption clause yields the same result. Congress did not intend to permit state taxation of ERISA plans. In enacting ERISA Congress rejected a request by the Executive Branch to exclude state tax laws from ERISA pre-emption. Indeed, state

taxes are expressly included within ERISA's broad pre-emption provision. True, state tax laws are pre-empted insofar as they "relate" to ERISA plans. But if a tax upon benefits and contributions — the very essence of ERISA plans — does not relate to the plans, it is difficult to conceive of a law that does. No case has ever ruled otherwise. Pre-emption of state taxation of contributions and other payments for healthcare benefits provided by ERISA plans furthers the basic purposes and objectives of ERISA: safeguarding plan assets, promoting nationally uniform administrative practices and benefit packages, and assuring use of plan assets exclusively for plan participants and their beneficiaries. Pre-emption of state taxes is consistent with the national system of tax exemption established by Congress for ERISA plans. The express Congressional design concerning state tax laws confirms what the commonsensical reading of the plain language of ERISA's pre-emption clause reveals — a state tax law, like the HFA, which directly taxes contributions and other payments for healthcare benefits provided by ERISA plans relates to the plans and is pre-empted.

The state and its supporting amici offer three principal arguments to evade pre-emption, none of which has merit. First, they hide behind the pretense that the HFA taxes the Fund not as an ERISA plan but as a hospital, or at most taxes the "benefits," not the plan. The fallacy here is that under ERISA a plan is defined as the provider of benefits. What the state and its allies call hospital functions are the very activities that make the Fund an ERISA plan. The distinction between the plan and the benefits it provides is equally specious. If the State were free to tax benefits, it could also regulate benefits, which this Court has repeatedly said it cannot do. Nor does the claim that the HFA is generally applicable to the healthcare field save it from pre-emption. The only laws of general applicability expressly exempted from ERISA pre-emption are state criminal laws. No other law of general application is afforded special treatment. Semantics cannot obscure the reality that when a state law taxes the activities which are the defining elements that qualify a plan for ERISA protection, that law relates to the plan and is pre-empted.

Second, the United States and NELA adopt a methodology that would confine pre-emption to those kinds of state laws that have already been held to be pre-empted. This categorization approach would transform ERISA's broad pre-emption clause into an extremely narrow provision. Congress has already rejected a like proposal of the Executive Branch to define pre-emption by subject matter. What the amici propose is nothing less than a petrification of the law, not an effectuation of the will of Congress.

Third, the State and its allies prophesy a general collapse of state healthcare regulation if the court of appeals is affirmed. Their alarm is unfounded. In earlier cases the Court has had occasion to comment on state laws that affect plans not as healthcare providers but in tangential roles incidental to plan activities — as purchasers, employers, lessees, etc. The Court has suggested that these kinds of laws are not pre-empted because they are too "tenuous, remote or peripheral." Laws governing the healthcare field manifestly relate to the plans *qua* plans and cannot be claimed to be tenuous, remote or peripheral. They may be saved from pre-emption on a case-by-case basis by application of a *Travelers* type analysis designed to unearth the intent of Congress. Given the presumption that Congress did not intend to pre-empt exercises of traditional state police powers, healthcare regulations may escape pre-emption. But the presumption applies only in the absence of a clear and manifest expression of Congressional intent to pre-empt. With respect to state tax laws that expression is contained in ERISA itself in a provision that expressly singles out these laws for inclusion in the pre-emption clause. The notion that by upholding Congress's express will in this case the Court would doom all state healthcare regulations is far-fetched. Far more foreboding is the likelihood that, if this Court should reverse, ERISA plans will be seen as easy targets for the states' ever burgeoning appetites for revenue.

ARGUMENT

I

ERISA PRE-EMPTS STATE LAW TO THE EXTENT IT DIRECTLY TAXES ERISA PLANS BASED UPON PAYMENTS AND CONTRIBUTIONS FOR HEALTHCARE BENEFITS FURNISHED TO PLAN PARTICIPANTS AND BENEFICIARIES BY MEDICAL CENTERS OWNED AND OPERATED BY THE PLANS

A. A Law That Taxes ERISA Plans Relates To ERISA Plans

ERISA § 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a) (1994).[6] The question in this case is whether a state law that taxes plan contributions and payments for benefits relates to an ERISA plan.[7] When a state law reaches into the coffers of an ERISA plan and extracts monies, it relates to that plan. To reach any other conclusion would do violence to the plan meaning of the language employed by Congress to express its pre-emptive intent.

This Court's decision in *Travelers* does not bode otherwise. *Travelers* did not purport to be a wholesale rewriting of the well established law of ERISA pre-emption.[8] The "relate to"

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[6] None of the specific exceptions to pre-emption delineated in the statute, *see* 29 U.S.C. § 1144(b) (1994), is applicable in this case. None has been invoked by the State.

[7] In this case the Fund does not challenge the imposition of the HFA in its entirety but only insofar as it applies to contributions and other payments for healthcare benefits provided by the Fund through its medical centers.

[8] The controlling test for determining whether a state law meets the "relate to" standard of ERISA § 514(a) is simple and direct: every state law that has a connection with or reference to an ERISA employee benefit plan relates to that plan and is pre-empted, whatever the state law's underlying

(Footnote continued)

standard is still the governing touchstone. It is still "deliberately expansive," *see Pilot Life*, 481 U.S. at 46, and "conspicuous for its breadth," *see FMC Corp.*, 498 U.S. at 58. "Relate to" still means having a connection with or reference to an ERISA plan. When the reference or connection is direct and self-evident, no further inquiry is necessary. Only when the nexus is not so clear cut, must the analysis explore all the surrounding circumstances, including the objectives of the ERISA statute, the language of its pre-emption clause, and the context of its legislative passage, to discern the type of state

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purpose and intent. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129-130 (1992); *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990); *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-97 (1983). The "relate to" standard must be interpreted broadly, *see Shaw*, 463 U.S. at 98; it must be given a "broad common sense meaning," *see Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990). The "relate to" touchstone does not limit ERISA pre-emption only to state laws specifically designed to regulate the terms and conditions of employee benefit plans or those dealing with the subjects of regulatory concern covered by ERISA — reporting, disclosure, fiduciary responsibility, and the like. *Ingersoll-Rand*, 498 U.S. at 137-39; *Shaw*, 463 U.S. at 98. Pre-emption prevails even if the state law is not specifically designed to affect ERISA plans or the state law's connection, reference, or effect is only indirect, *see Greater Wash. Bd. of Trade*, 506 U.S. at 129-130; *Ingersoll-Rand*, 498 U.S. at 139; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987), or the state law is "consistent with ERISA's substantive requirements," *see Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). Nor does a state law automatically escape ERISA's pre-emptive reach merely because it is a general law not specifically designed to affect employee benefit plans. *Shaw*, 463 U.S. at 96-98. If the state law relates to an employee benefit plan, it is pre-empted regardless of its status as a law of general application. *Morgan Guar. Trust Co. v. Tax Appeals Tribunal*, 80 N.Y.2d 44, 49, 587 N.Y.S.2d 252, 255, 599 N.E.2d 656 (1992). "Even in the absence of an express link to an employee benefit plan, State law is preempted 'insofar as' the law applies to benefit plans in particular cases." *Morgan Guar.*, 80 N.Y.2d at 49, 587 N.Y.S.2d at 255 (citing *Shaw*, 463 U.S. at 97 n. 17). Only when the state law's connection to the ERISA plan is "too tenuous, remote, or peripheral," might the state law be saved from ERISA's pre-emptive grasp, *see Shaw*, 463 U.S. at 100 n.21, "as is the case with many laws of general applicability," *see Greater Wash. Bd. of Trade*, 506 U.S. at 130.

law Congress intended to displace. *Travelers*, 115 S. Ct. at 1677, 1680.

This Court's prior ERISA pre-emption cases conform to this approach. In *Mackey v. Lanier Collection Agency & Serv., Inc.*,486 U.S. 825 (1988), it took the Court, with no objection by the four dissenting justices, *id.* at 841, less than two pages to find a provision of the Georgia garnishment law that expressly exempted ERISA plans pre-empted because "[t]he state statute's express reference to ERISA plans suffices to bring it within the federal law's preemptive reach." *Id.* at 830. The Court's later decision in *Greater Wash. Bd. of Trade* reaffirmed the principle that a state law having a specific reference to ERISA plans "on that basis alone is pre-empted." 506 U.S. at 130.

The lesson of *Mackey* and *Greater Wash. Bd. of Trade* is not limited to those cases involving state laws that contain specific reference to ERISA plans. Obviously, when the language of the state statute refers expressly and directly to ERISA plans, there is no question that the state law satisfies the "reference to" prong of the "relate to" test. A state law may also satisfy the "connection with" prong in a similarly unmistakable fashion when it applies manifestly to ERISA plans. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (state law requiring all health insurance contracts to provide minimum mental healthcare benefits indisputably relates to insured ERISA plans but is exempted from pre-emption by insurance savings clause); *Alessi v. Raybestos-Manhattan, Inc.*,451 U.S. 504, 524-25 (1981) (anti-set-off provision of workers' compensation law relates to ERISA plans because it prohibits one method for calculating benefits that is permitted by federal law). Certain state laws have so unmistakable a connection with ERISA plans that no honest appraisal can conclude that they do not relate. When the ball flies over the center field fence, the umpire does not have to refer to the foul poles. *See, e.g., Alessi*, 451 U.S. at 525 (relationship of state law to ERISA plans so clear that there was no need to "determine the outer bounds of ERISA's

pre-emptive language to find this New Jersey provision an impermissible intrusion on the federal regulatory scheme").

When the state law applies to ERISA plans indirectly, the pre-emption analysis becomes more complicated. In *Mackey,* when the Court addressed the less pellucid issue of whether that portion of the Georgia garnishment statute which contained no direct reference to ERISA plans was pre-empted, a far more expansive analysis ensued, provoking a sharp division in the Court. To ascertain whether a law of indirect application relates to ERISA plans requires the kind of analysis engaged in by the *Travelers* Court. A state law that directly taxes ERISA plans does not.

Unless the tax law relates, the ERISA plan would not have to pay the tax. It is true that a tax law may have a connection to an ERISA plan that does not rise to the level of actually imposing an exaction on the plan itself. *See, e.g., Thiokol Corp. v. Roberts,* 76 F.3d 751 (6th Cir. 1996), *petition for cert. pending,* No. 95-1913 (U.S. filed May 23, 1996) (business tax upon employer based in part upon its contributions to ERISA plans held not pre-empted). In those situations a *Travelers* analysis may be appropriate. But when the state enactment reaches into the plan's coffers to siphon off monies, the connection is so direct and unmistakable as to leave no doubt that it relates to the plan. Let the State and its allies tell the taxpayers on April 15 that the Internal Revenue Code does not relate to them.

B. Even Under A *Travelers* Analysis The New York Tax Is Pre-empted

Application of the methodology employed by this Court in *Travelers* leads to the same conclusion, that the HFA relates to ERISA plans. The *Travelers* Court underscored the primacy of Congressional intent in determining what state laws are supplanted by ERISA pre-emption, and Congress has left no doubt that it did not intend to exempt state tax laws of general applicability from ERISA's pre-emption provision.

When ERISA was first under legislative consideration in 1974, Congress rejected a request by the Secretaries of Labor and Treasury to exclude state tax laws from ERISA pre-emption. *Northwest Airlines v. Roemer,* 603 F. Supp. 7, 12 (D. Minn. 1984). In 1983 Congress added a specific provision reaffirming that ERISA's pre-emption clause applied to state tax laws. This provision contains a clear and unambiguous statement of Congressional intent to include within ERISA's pre-emptive embrace "any State tax law relating to employee benefit plans." 29 U.S.C. § 1144(b)(5)(B)(I) (1994). The conference report explained that this statutory directive assured that "preemption is continued with respect to . . . any state tax law relating to employee benefit plans . . . ." H.R. CONF. REP. No. 984, 97th Cong., 2d Sess. 18 (1982), *reprinted in* 1982 U.S.C.C.A.N. 4603.

This addition to ERISA's pre-emption clause was enacted as part of a legislative package containing a Congressional dispensation for Hawaii's Prepaid Health Care Act that expressly saved that state enactment from ERISA's pre-emptive reach. *See generally Retirement Fund Trust of Plumbing v. Franchise Tax Bd.,* 909 F.2d 1266, 1277-78 (9th Cir. 1990) (explaining the legislative history of the special exemption afforded Hawaii's healthcare legislation under ERISA). In introducing the special Hawaiian legislation on the Senate floor, Senator Dole said:

> The bill amends ERISA to provide that Hawaii law relating to employer maintained health insurance plans would not be preempted by ERISA to the extent that the Hawaiian law does not relate to matters thoroughly regulated under ERISA or *impose tax liability on insurance premiums or benefits.*

128 CONG. REC. S26902 (daily ed. Oct. 1, 1982) (emphasis added).

There is a clear and unequivocal Congressional policy to shield ERISA plans from the destructive effects of taxation. Congress has meticulously put into place throughout the

Internal Revenue Code a national system of tax exemptions for ERISA plans. Contributions to ERISA plans are deductible and tax exempt. *See, e.g.*, 26 U.S.C. § 404 (1994) (pension and annuity plans); 26 U.S.C. §§ 162, 419, 419A (1994 & Supp. I 1995) (welfare benefit plans); 26 U.S.C. § 79 (1994) (employer-paid cost of life insurance); 26 U.S.C. § 106 (1994) (contributions to disability plans). Income earned through the investment of plans' assets is tax-free. *See, e.g.*, 26 U.S.C. §§ 501(a), 501(c) (1994) (pension and welfare plans). Benefits received from welfare plans are tax-exempt. *See* 26 U.S.C. §§ 104, 105, 106 (1994) (accident and health benefits); 26 U.S.C. § 101 (1994) (death benefits); 26 U.S.C. § 129 (1994) (dependent care benefits). Benefits received from pension plans are tax-deferred; pension benefits are nontaxable while held by ERISA plans and only become taxable when ultimately received by the beneficiary. *See* 26 U.S.C. §§ 402, 403 (1994). ERISA's pre-emption clause preserves this uniform, nationwide system of tax exemptions from the unsettling effects of conflicting state tax policies.

The court of appeals in this case applied the ordinary, commonsensical meaning of the statutory "relate to" standard and found that a state tax assessment levied upon employer and employee contributions to a medical center operated by an ERISA welfare plan to provide medical benefits to plan beneficiaries has a direct connection to the plan and is pre-empted, not in its entirety but only insofar as it assesses those contributions. Indeed, every court that has addressed a state tax law that directly assesses plan contributions or plan benefits has found that the state enactment relates to ERISA plans and is pre-empted. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir.), *cert. denied*, 502 U.S. 981 (1991) (tax on healthcare benefits paid by plan); *General Motors Corp. v. California State Bd. of Equalization*, 815 F.2d 1305, 1309 (9th Cir. 1987), *cert. denied*, 485 U.S. 941 (1988) (tax computed on basis of healthcare benefits paid by plan); *Birdsong v. Olson*, 708 F. Supp. 792, 798-799, 801 (W.D. Tex. 1989), *appeal dismissed*, 901 F.2d 1270 (5th Cir. 1990) (tax on healthcare benefits paid by plan); *National Carriers' Conference Comm. v. Heffernan*, 454 F. Supp. 914, 917-18 (D. Conn. 1978) (same).[9]

Congress expressly included within the scope of ERISA's pre-emption clause state tax exactions. Anything less would have encouraged the various states to impose their individual tax levies upon the treasuries of ERISA plans. "The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation." *E-Systems*, 929 F.2d at 1103; *see also Northwest Airlines*, 603 F. Supp. at 12; *National Carriers' Conference Comm.*, 454 F. Supp. at 917.[10]

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[9] The only state tax laws that have survived ERISA pre-emption are business taxes imposed upon employers that include in the tax base contributions paid by employers to ERISA employee benefit plans, *see Thiokol Corp. v. Roberts*, 76 F.3d 751, 753-56 (6th Cir. 1996), *petition for cert. pending*, No. 95-1913 (U.S. filed May 23, 1996), and withholding and tax delinquency-garnishment procedures that assess not the plan but the beneficiary, *see Retirement Fund Trust of Plumbing v. Franchise Tax Bd.*, 909 F.2d 1266, 1281 (9th Cir. 1990); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 556 (6th Cir. 1987); *see also Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (monies subject to state garnishment had already been earmarked for judgment debtor so that application of state garnishment law did not affect amount of plan benefits due other beneficiaries); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) (same result for state escheat law). None of these state tax laws had any effect upon the amount of plan benefits or contributions, and thus their connection to ERISA plans was tenuous, remote, and peripheral — an insufficient nexus to trigger pre-emption. *Thiokol*, 76 F.3d at 754-55.

[10] The HFA unquestionably increases the cost to the Fund of providing beneficiaries with a given level of healthcare benefits. The outside employers' man-hour contributions are effectively lowered by the amount of the assessment. Similarly, the NYSA-PPGU Welfare Plan's payments, which are essentially benefit payments for its own beneficiaries, must be increased so that the Fund and its medical centers can recoup the added costs caused by the HFA assessment. The state levy also disrupts the balance struck between employer contributions and employee prescription and registration payments, reducing the effectiveness of these employee contributions in helping to defray healthcare costs. Obviously, if the state

(Footnote continued)

The Congressional treatment of state tax laws within the context of ERISA pre-emption exposes the fallacy of the interpretation of *Travelers* propounded by the State and its amici supporters. *See* PB at 14; HA at 4. *Travelers* does not, as they suggest, stand for the proposition that state laws whose only impact on ERISA plans is economic are saved from pre-emption. First, there is nothing in the *Travelers* decision that supports this reading. The ruling of the *Travelers* Court was limited to indirect economic impacts of an insubstantial nature. *See* 115 S. Ct. at 1683. Second, tax laws by their very nature have as their necessary effect a purely economic impact on the affected taxpayer. If economic impact alone could never trigger pre-emption, the explicit Congressional directive to include state tax laws that relate to ERISA plans within the reach of ERISA pre-emption is rendered meaningless. Adoption of the suggestion urged by the State and its allies would effectively read the directive out of the statute, a result that would violate basic principles of statutory construction. *See Travelers*, 115 S. Ct. at 1679-80.

To shield state tax enactments from ERISA pre-emption would be inconsistent with the basic "objectives of the ERISA statute" — a key guide to defining the scope of ERISA pre-emption. *Id.* at 1677.[11] Subjecting ERISA plans to the taxing

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levy increases the cost of medical and related healthcare services, ERISA plans must reduce benefits to stay within their budgetary restrictions or charge their beneficiaries more for the benefits unless the union representatives of the plan participants prevail in persuading their employers at the bargaining table to increase the level of employer contributions.

[11] The function of federal pre-emption is to give effect to the "full purposes and objectives" of federal legislation, *see Hines v. Davidowitz*, 312 U.S. 52, 67-68 (1941), since, under the Supremacy Clause of the Constitution of the United States, federal law is "the supreme Law of the Land" to which "any Thing in the Constitution or Laws of any State to the Contrary" must yield. U.S. CONST., ART. VI, CL. 2. In determining whether federal law pre-empts state law, "[t]he purpose of Congress is the ultimate touchstone." *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978) (quoting *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103 (1963)); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). When Congress adopts a broadly worded express pre-emption provision in the federal legislation, *(Footnote continued)*

powers of 50 separate and distinct jurisdictions would frustrate the Congressional objective of allowing ERISA plans to adopt nationally uniform administrative practices and interstate benefit packages, which the *Travelers* Court identified as one of the principal goals of ERISA pre-emption. *See Travelers*, 115 S. Ct. at 1677-78. State taxation of plan benefits and plan contributions would be incompatible with this Congressional objective. Benefits would vary from state to state depending upon the magnitude of each state's tax bite. This Congressional objective is implicated in this very case.

The Fund had to restructure its payment procedures in response to the state exaction. Since July 1992 registration fees and payments from the NYSA-PPGU Welfare Fund have been remitted to the Fund, not to the medical centers. Although the Fund can redirect to the Fund all payments now received by the medical centers and thus effectively override the HFA, it has not yet done so. Incentives that induce or encourage changes in plans' traditional methods of administration are features of state regulation that ERISA pre-emption was designed to prevent. *See National Carriers' Conference Comm. v. Heffernan*, 454 F. Supp. 914, 918 (D. Conn. 1978). When the affected ERISA plan provides multi-state coverage, as does the Fund here, the state scheme has the effect of disrupting uniform administrative procedures that apply across state lines. The New York tax at issue in this case has no New Jersey counterpart and would require the Fund to restructure its established method of administration to implement procedures for its New York medical clinics that differ from those of its New Jersey clinic (App. 17). Any state law that forces a plan to restructure its administrative procedures or to adopt different methods on a state-by-state basis relates to an ERISA plan and is pre-empted. *FMC Corp.*, 498 U.S. at 59-60; *Alessi*, 451 U.S. at 524.

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the "task of discerning congressional intent is considerably simplified." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990).

To shield state tax enactments from ERISA pre-emption would also be inconsistent with the Congressional objective of safeguarding plan assets. ERISA was promulgated principally to protect the interests of plan participants by assuring "the soundness and stability of plans with respect to adequate funds to pay promised benefits." 29 U.S.C. § 1001(a) (1994); *see Northeast Dep't ILGWU Health & Welfare Fund v. Teamsters Local 229 Welfare Fund,* 764 F.2d 147, 158 (3d Cir. 1985) ("Resolution of the issue will affect not only the interests of beneficiaries, whose welfare it was the prime purpose of ERISA to protect, but also the interests of benefit trust funds, the solvency of which was a matter of serious congressional concern").

To shield state tax enactments from ERISA pre-emption would also be inconsistent with a third Congressional objective. ERISA requires that employee benefit plans expend plan funds solely for the benefit of plan participants and their beneficiaries. 29 U.S.C. § 1103(c)(1) (1994). Indeed, it would be a violation of § 302 of the Labor Management Relations Act, 29 U.S.C. § 186 (1994 & Supp. I 1995), to use trust assets to benefit persons other than plan beneficiaries. *See In re Typo-Publishers Outside Tape Fund,* 478 F.2d 374, 375-76 (2d Cir.), *cert. denied,* 414 U.S. 1002 (1973); *Blassie v. Kroger Co.,* 345 F.2d 58, 68 (8th Cir. 1965). Even if trustees wanted to donate plan money to help the indigent, ERISA's exclusive benefit requirement would prohibit them from doing so. Any state law that mandates this ERISA violation would clearly relate to ERISA plans because it effectively enrolls strangers on the roster of plan beneficiaries. *Bricklayers Local 1 Welfare Fund v. Louisiana Health Ins. Ass'n,* 771 F. Supp. 771, 775 (E.D. La. 1991) (ERISA preempts use of assets of ERISA plans to establish fund to finance hospital care for those suffering from catastrophic illnesses). How much more violative of Congress's purpose is a state law that expropriates plan assets for the benefit of the general public.

To sacrifice plan solvency, uniformity, and exclusivity to the appetite of state tax collectors would contravene the very ERISA purposes Congress had in mind when it included state

tax laws within the reach of ERISA's pre-emption clause. In light of this express Congressional design, which the *Travelers* Court considered to be of decisive importance in pre-emption analysis, it is difficult to find a state law that more clearly relates to ERISA plans than one which directly taxes contributions and payments for benefits provided to plan participants and their beneficiaries. The *Travelers* analysis thus confirms what the commonsensical reading of the plain language of ERISA's pre-emption clause reveals — that the HFA relates to ERISA plans and is pre-empted.

II

AN ERISA PLAN AND ITS OPERATIONS CANNOT BE BIFURCATED TO EVADE PRE-EMPTION

The main argument propounded by the State and its amici is an exercise in semantic manipulation. They claim that the HFA is not pre-empted because it is imposed upon the Fund in its capacity as a "provider of medical services," not as a "plan." *See* PB at 16; SG at 25; HA at 19; NELA at 19; AG at 12, 20 n.8. This ontological argument is premised upon a fundamental error. The State and its allies pretend that ERISA employee welfare benefit plans are not themselves the providers of healthcare benefits but exist only as self-insurers or purchasers of healthcare insurance that will be used to pay the actual healthcare providers. Somehow the definition adopted by Congress has been lost in the shuffle.

An employee welfare benefit plan is "any plan, fund, or program . . . established or . . . maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise," healthcare and other benefits. 29 U.S.C. § 1002(1) (1994). An ERISA plan, therefore, is not merely an insurer. It provides healthcare benefits. This may be done by paying beneficiaries' healthcare bills or by reimbursing the beneficiaries or by obtaining outside, commercial insurance. It can also be done "otherwise," *i.e.*,

by furnishing medical, surgical, or hospital care directly through clinics and other healthcare facilities.[12] In dispensing care and treatment at its clinics the Fund is engaging in the very activity that brings it within the ERISA definition of an employee welfare benefit plan.

To pretend that an ERISA plan enjoys a hypostatic union in which its two natures coexist simultaneously without commingling borders on the nonsensical. It is equally fatuous to say that the Fund "chooses" to act as a hospital. *See* SG at 25; AFSCME at 4. It is an essential nature of the Fund to act as the direct provider of medical care. What the State and its allies call hospital functions are the very activities that make the Fund an ERISA plan.

The State buttresses its argument by suggesting that the medical centers operated by the Fund are essentially no different than any general, commercial facility. *See* PB at 16; *see also* AFSCME at 13. This paints a false picture. The Fund's clinics are not commercial enterprises. They are not open to the general public. They are not operated for profit. They cannot pass on the HFA or other state taxes to their "customers." They do not compete with other healthcare facilities for their clientele. They exist purely and simply to provide ERISA welfare benefits to plan participants and their beneficiaries. Recognition of the true nature of the Fund's activities refutes the assumption that the Fund is similarly situated to other healthcare providers and should be similarly treated. *See* SG at 25.[13]

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[12] The United States and other amici recognize that ERISA plans are increasingly electing to provide benefits directly. *See* HA at 9-10 & n.6 (day care centers and clinics); AG at 9 (day care centers, legal services programs, and medical centers); SG at 29 (day care centers and funeral homes).

[13] The Fund's clinics are more akin to the kinds of institutions which the New York statute itself exempts from the tax: voluntary nonprofit hospitals totally financed by charitable contributions, facilities dedicated solely to the care of police, firefighters, and emergency service personnel, etc. N.Y. PUB. HEALTH LAW § 2807-d(b) (McKinney 1993). Of course, the

(Footnote continued)

A leitmotif that trills throughout the briefs of the State and its allies is the claim that the HFA is a law of "general application." *See* PB at 11; SG at 25; AG at 12-13; NGA at 8; AFSCME at 13- 17. The observation offers little solace. General applicability is not a talisman that magically shields state laws from ERISA pre-emption. General applicability *per se* is insufficient to avoid pre-emption; a state law does not have to target an employee benefit plan directly in order to be pre-empted by ERISA, *see Pilot Life*, 481 U.S. at 47. The very language of ERISA's pre-emption clause dispels the notion that Congress reserved for state laws of general applicability a special status that renders them less susceptible to pre-emption. The only mention of a state law of general application appears in ERISA § 514(b)(4), which exempts from ERISA pre-emption "any generally applicable *criminal* law of a State." 29 U.S.C. § 1144(b)(4) (1994) (emphasis added). No other generic law of general application is afforded special treatment.[14]

State tax laws, which sweep broadly and usually apply to the entire taxpaying public, were explicitly singled out by Congress to assure that there would be no misunderstanding that they are subject to ERISA's express pre-emption clause regardless of their general applicability. HFA, then, is not any less susceptible to ERISA pre-emption merely because it happens to be a state tax. The language of ERISA's pre-emption clause as well as its legislative history indicate that Congress intended to pre-empt state tax laws of general applicability to

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New York Legislature could not add ERISA plan facilities to the list of exemptions without incurring automatic pre-emption under the rule in *Mackey*.

[14] Because of the categorical application of ERISA's pre-emption clause to state laws of general application, only Congress can save specific state enactments from ERISA's pre-emptive reach. Hawaii's Prepaid Health Care Act, generally applicable to all employers in that state, would have been pre-empted by ERISA despite its status as a law of general application, were it not for an express Congressional dispensation. *See* 29 U.S.C. § 1144(b)(5) (1994).

the same extent as other laws insofar as they relate to ERISA employee benefit plans.

The HFA's tax on contributions and payments for benefits affects ERISA plans *qua* employee benefit plans; it goes to the very activities and functions that make employee benefit plans what they are. As the Second Circuit observed, "It does not touch the Fund only slightly on the outer limits of its plan activities; it affects the very operations and functions that make the Fund what it is, a provider of medical, surgical, and hospital care to its participants and their beneficiaries" (App. 16). It is hardly remarkable that Congress intended the express pre-emption clause of ERISA to proscribe state assessments that sap the lifeblood of ERISA plans and directly hinder their essential functions.

The State proffers a second semantic gyration, a variation of its ontological argument. It claims that "ERISA is concerned with the administrative structure established to provide the benefits, not the benefits themselves" and that the state law "relates, at most, to the benefit provided by the plan, not to the plan itself." *See* PB at 23-24. The State in essence would have it that the only kind of connection that would trigger pre-emption is where the state law would interfere with the administration of the plan. *See* PB at 23-25; *see also* HA at 16-19. Manifestly, ERISA plans exist for the purpose of providing benefits. All the structure and administration of the plan is geared to that end. ERISA plans do not provide benefits so that they may engage in administration; they are administered so that they may provide benefits. The State's suggestion that laws which interfere with administration are pre-empted but laws that interfere with the ability to provide benefits are not turns ERISA pre-emption on its head. The State's position would permit the states to regulate ERISA benefits without incurring pre-emption, a position directly at odds with prevailing law. *See Shaw*, 463 U.S. at 97 (state law mandating pregnancy benefits is pre-empted); *Metropolitan Life*, 471 U.S. at 730 n.11, 735 n.14 (state law mandating minimum mental health benefits would have been pre-empted but for insurance savings clause).

Semantics cannot obscure the reality that when a state law taxes the activities which are the defining elements that qualify a plan for ERISA protection, that law relates to the plan and is pre-empted.

III

ERISA PRE-EMPTION IS NOT CONFINED TO THE KINDS OF STATE LAW THAT HAVE ALREADY BEEN ADDRESSED BY THE COURT

The United States and NELA purport to provide the Court with a calculus for determining what state laws ERISA pre-empts. The United States distills from the Court's prior decisions three types of laws that are likely to be pre-empted — those which pertain to subjects already regulated by ERISA, *see* SG at 12-14, those which specifically refer to ERISA plans, *see id.* at 14-16, and those which mandate or prohibit benefits provided by ERISA plans, *see id.* at 17-19. The United States then proposes a fourth scenario in which it claims there is no pre-emption, *see id.* 19-23 — a situation that just happens to match the characterization of the facts in this case urged by the State and its cohorts. This last item does not rightly belong in the series. It is not parallel to the other three. It is not a scholarly synthesis of legal precedent but an advocate's argument. Its derivation is not what the Court has decided in the past but what forces aligned with the State hope the Court will rule in this case.

One should not be deceived by the Government's bait and switch. The fact that it tags its argument onto a series of legal distillations does not elevate it to their level. The Government's first three dissertations have nothing to do with this case. The HFA is not the kind of state law they describe, and the Fund does not urge pre-emption on those grounds. The Government's argument must stand or fall on its own merits and does not deserve the halo effect the Government seeks to obtain by its strategic placement.

Nor should one be deceived by the Government's *sotto voce* suggestion that unless a state law falls into one of the first three categories, it must necessarily fall into the fourth and thus escape pre-emption. This theme is given full rendition by another amicus. NELA constructs five situations when ERISA pre-empts state laws[15] and sets them against a presumption that a state law in an area of traditional state regulation is not pre-empted. NELA then argues that the New York law in this case escapes pre-emption because it is not one of the five pre-empted types. *See* NELA at 20.

This approach converts adjudication into a process of categorization. Prior pre-emption cases are divided into two types: those in which the state law was pre-empted and those in which the state law survived the pre-emption challenge. The Government and NELA jump to the conclusion that, if a state law does not fall within the first category, it necessarily falls within the second.

By developing principles that impose boundaries beyond which pre-emption will not extend, the approach of synthesizing existing case law circumscribes the conspicuously broad ERISA pre-emption clause to those specific situations where courts have already found pre-emption. Under this approach a state law would relate to an ERISA plan only if it resembled another state law that a prior court decision found pre-empted. It is not a judicial function to erect fences where the legislature has not. Existing case law has hardly exhausted all the possible ways in which state statutes could relate to ERISA plans. To limit pre-emption to what has already been decided is to transform an extremely broad pre-emption provision into a very narrow one. This formulation parallels that of the Executive Branch, which had sought to define ERISA

[15] According to NELA, pre-emption is triggered when the state law (1) directly conflicts with ERISA, *see* NELA at 11, (2) involves a claim that may be brought under ERISA, *see id.* at 12, (3) specifically refers to an ERISA plan, *see id.* at 13, (4) regulates an ERISA-governed relationship, *see id.* at 15, and (5) accomplishes through a severe indirect economic effect what it could not do directly, *see id.* at 19.

pre-emption by example or subject matter — an approach already rejected by Congress, *see Shaw*, 463 U.S. at 98 n. 19, and one that would lead not to the accomplishment of the legislative will but to the petrification of the law.

Another fallacy in the categorization approach is the setting up in contradistinction to state laws that have been pre-empted state laws involving areas of "traditional state regulation." It cannot be denied that this case arises within the area of healthcare or that that area is one of traditional state regulation. The error is that the state law in this case is not the regulation of healthcare. It is the imposition of a tax.

Taxation is often used as a means of regulation, such as protective tariffs or prohibitive excises on the sale of dangerous weapons. But the New York law in this case has no underlying regulatory motivation. It is a revenue raising measure (App. 32, 48; *see also* SG at 2). It has no other purpose but to swell the coffers of the State's treasury.[16]

The Fund has never claimed that it is immune from genuine state regulatory laws, like those governing the staffing and operations of medical facilities, *see* PB at 20. As to these

[16] The distinction between a regulation and a tax has already made an appearance in the jurisprudence of ERISA pre-emption. When the experimental prototype of Hawaii's prepaid healthcare law was challenged under ERISA pre-emption, one of Hawaii's defenses was that the law was an exercise of its sovereign taxing authority, immune from pre-emption by the Tenth Amendment. The Ninth Circuit rejected the defense, holding that the law was a regulation, not a tax, because any imposition did not find its way into the sovereign's purse. *Standard Oil Co. of Cal. v. Agsalud*, 633 F.2d 760, 765 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981). The issue evaporated when this Court in *Garcia v. San Antonio Metropolitan Transit Auth.*, 469 U.S. 528 (1985), overruled *National League of Cities v. Usery*, 426 U.S. 833 (1976), the case on which Hawaii's sovereignty analysis rested. *See Retirement Fund Trust of Plumbing v. Franchise Tax Bd.*, 909 F.2d 1266, 1277 n. 43 (9th Cir. 1990). What did not disappear was the distinction between taxation and regulation, and Congress in its later dispensation for the Hawaii healthcare legislation felt constrained to add to ERISA the provision expressly including state tax laws within the ambit of the pre-emption clause. *See id.* at 1277-78.

regulatory measures the presumption that Congress does not lightly interfere with the historic police powers of the states may apply. That the presumption applies to the state's revenue raising measures is far less certain. But even if the presumption did apply, it fails in the presence of a clear and manifest Congressional intent to supplant the state laws. *Travelers,* 115 S. Ct. at 1676. ERISA contains an express declaration that state tax laws enjoy no charmed existence from ERISA pre-emption. If they relate to ERISA plans, they are pre-empted.

IV

PRE-EMPTION OF A DIRECT TAX ON ERISA PLANS DOES NOT THREATEN ALL STATE HEALTHCARE REGULATION

Ultimately the State and its allies take refuge in prophesies of gloom and doom. They predict that if this Court rules that the Fund is not subject to the New York HFA, it will mean that ERISA plans will be free of a myriad of state regulations affecting all kinds of benefits provided by ERISA plans from healthcare to legal services. *See* PB at 20; SG at 29; AG at 6-10; HA at 14-16; AFSCME at 11, 13; NGA at 15-16. They conjure up images of unqualified nurses, unprotected children, unethical lawyers, and unembalmed bodies if the decision of the court of appeals is reversed. Some even foretell of a mass emancipation from state regulation of virtually all healthcare providers through the device of transforming themselves into ERISA plans. *See* HA at 9-11.

The "tenuous, remote or peripheral" standard, *see Shaw,* 463 U.S. at 100 n. 21, disposes of most types of state regulation. The focus of this standard is the nature of the state law's effect on ERISA plans. When the state regulation touches the plan only slightly on the outer limits of its activities, the state law's connection to the plan may well be too tangential to satisfy the "relate to" test that triggers pre-emption.

The "tenuous, remote or peripheral" standard assures that the Congressional objective embodied in ERISA's

pre-emption clause is properly effectuated. Pre-emption is designed to proscribe state regulation when the state law relates to an ERISA plan *qua* an employee benefit plan, *i.e.,* when the state law affects the very activities and functions that make the employee benefit plan what it is. *Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1, 7 (1987) ("ERISA's pre-emption provision does not refer to state laws relating to 'employee benefits', but to state laws relating to 'employee benefit *plans*'" (emphasis in original)).

Obviously, Congress could not have intended to shield plans from the normal incidents of state regulation that affect private enterprises generally. ERISA plans do not operate in a vacuum. A necessary incident of their activities requires them to perform functions that are not peculiar to employee benefit plans but are carried on by other private entities. ERISA plans hire employees, rent office space, and purchase goods and services. Congress could not have intended ERISA's pre-emption clause to foreclose state regulation of employee benefit plans when they act not as plans but as employers, lessees, or purchasers. *Cf. Mackey,* 486 U.S. at 833 (ERISA plans are not relieved from state law liability for unpaid rents, failure to pay creditors, or tortious conduct). By the same token state taxes and assessments that do not implicate the administration of employee benefit plans but arise as a result of transactions which any other enterprise might engage in do not trigger pre-emption because they are too remote, tenuous, or peripheral. Sales taxes, utility taxes, and gasoline taxes are some of the state levies that would fall into this non-pre-empted category.

The only real problem arises with respect to those state regulations directly involving healthcare: staffing requirements, nursing and physician standards, sanitary regulations involving disposal of medical waste, etc. These provisions which apply to plans as the providers of healthcare benefits are affecting the plans *qua* plans. It does not take Jamesian metaphysics to see that they relate to ERISA plans. *Travelers,* 115 S. Ct. at 1677. Nor can one honestly say that the

relationship is tenuous, remote or peripheral, since it goes to the essence of the plans' ERISA status.

It is precisely in this area that the Court's decision in *Travelers* offers the solution. The touchstone is the intent of Congress. The starting point of that analysis is the presumption that the exercise of historic state police powers is not pre-empted. *Travelers* observed that there was no indication of a clear Congressional intent in ERISA to pre-empt traditional state healthcare regulation. None of these regulatory measures is specifically mentioned in ERISA's pre-emption provision. It would appear, therefore, that the regulations about which the State and its allies are so concerned would survive. But that is not this case. This case involves not healthcare regulation but taxation, and as to taxation the ERISA pre-emption clause does contain an explicit expression of Congressional intent to pre-empt. As to the other types of regulation, which are the subject of the doomsaying of the State and its allies, the question of their susceptibility to ERISA pre-emption must be decided on a case-by-case basis. What is important here, however, is that it does not necessarily follow, that, if this Court invalidates a state tax, which Congress expressly included within the ambit of ERISA pre-emption, on the very activities that make the plan a plan, all peripheral state regulation of plan activities must also fall.

A far more realistic prediction of mischief that might follow upon a decision of this Court arises if the Second Circuit's decision should be reversed. In that event the states will have been given the green light to directly tax the contributions and benefits of ERISA plan. If the arguments of the State and its allies are accepted, it is difficult to conceive of any state tax that would be pre-empted. After all, state taxes, especially income taxes, are laws of general applicability involving traditional exercises of state police power that affect plans not as plans but as taxpayers. The states' appetites for money are without limit. ERISA plans provide an available fatted calf. Ominous stirrings already appear in the *amicus* brief to this Court filed on behalf of more than half the states of the Union. *See* AG at 12-14.

One can take no comfort from either the low rate of the HFA or the modest amount of the tax bite at issue. If there is anything so sure as death and taxes, it is that tax rates will rise. One need only remember the original levies under the Sixteenth Amendment. Moreover, the rate alone does not determine the amount of a tax. Definitions of the taxable transaction or tax base and of deductible items are often more instrumental in establishing the severity of the tax bite. During the pendency of this litigation the State has seen fit not to challenge the Fund's position that payment to medical centers to meet operating budgets are not subject to the HFA. Should the State prevail in this court, there is nothing to prevent it from expanding its definition of receipts to include the Fund's entire $20 million annual budget, yielding a tax of more than $120,000 per year.

Even the $7,000 figure now at issue has a real and substantial effect on the Fund's ability to provide benefits. Unlike businesses, the Fund cannot pass the tax on to its customers. Any HFA assessment must come out of the finite pool of monies contributed to the Fund. No matter how small the levy, there will be that much less to pay for plan benefits. To the individual participant who has to dig into his own pocket when the Fund is unable to provide free treatment, the hardship is considerable.

CONCLUSION

The court of appeals in this case, as did every other tribunal that has entertained the same question, applied established precedent to invalidate the immediate and direct imposition of a state tax levy on contributions to, and benefit payments of, an ERISA plan. The decision below is perfectly consistent with the analytical methodology adopted by this Court in *Travelers,* since it gives effect to Congressional intent, the touchstone for ERISA pre-emption. It rests squarely upon a clear and explicit Congressional policy to pre-empt state tax impositions on ERISA plan contributions and benefits. The decision below, therefore, is in perfect harmony with established principles of ERISA pre-emption law and should not be disturbed. The judgment of the court of appeals should be affirmed.

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Respectfully submitted,

THOMAS W. GLEASON
ERNEST L. MATHEWS, JR.*
GLEASON & MATHEWS, P.C.
26 Broadway - 17th Floor
New York, New York 10004
(212) 425-3240

C. PETER LAMBOS
DONATO CARUSO*
LAMBOS & JUNGE
29 Broadway - 9th Floor
New York, New York 10006
(212) 943-2470

Co-Counsel To Respondents
*(*Counsel of Record)*

No. 95-1594

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

—against—

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

REPLY BRIEF FOR PETITIONERS

BARBARA G. BILLET
Solicitor General

PETER H. SCHIFF
Deputy Solicitor General

DANIEL F. DE VITA
Assistant Attorney General
in Charge of Labor Bureau

M. PATRICIA SMITH*
Assistant Attorney General

* *Counsel of Record*

DENNIS C. VACCO
Attorney General of the
State of New York
120 Broadway
New York, New York 10271
(212) 416-8707

Attorney for Petitioners

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IN THE

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Respondents.

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REPLY BRIEF FOR PETITIONERS

This brief is submitted by petitioners (referred to collectively as "the State") in response to the brief filed by respondents, trustees of the NYSA-ILA Medical and Clinical Services Fund ("the Fund"), and their *amici*. In support of its argument that the Health Facility Assessment ("HFA") is pre-

empted, insofar as it is applied to Fund-owned medical centers, the Fund attempts to distinguish the application of the HFA to its medical centers from the application of the HFA to non-ERISA plan-owned hospitals, from other generally applicable taxes, and from other State regulation of the Fund's medical centers. The Fund's effort to distinguish the HFA from the surcharges at issue in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. ___, 115 S. Ct. 1671 (1995) ("*Travelers*"), and to carve out the result it desires in this case, does not withstand scrutiny. The Fund cannot distinguish the HFA from the surcharges upheld in *Travelers*. Nor can it adequately explain why even the most narrow application of its theory would not require the preemption of all state regulation where an ERISA plan opts to provide healthcare benefits in-kind.

I. GENERALLY APPLICABLE TAXES DO NOT RELATE TO AN ERISA PLAN SIMPLY BECAUSE THE PLAN PAYS THE TAXES

The Fund first argues that no extended analysis, such as that in which this Court engaged in *Travelers*, is necessary in this case because the connection between the HFA and the Fund is "clear and unmistakable." The Fund pays the tax and "unless the tax law relates, the ERISA plan would not have to pay the tax" (Resp. Br. 16).[1] This theory of ERISA preemption of state tax laws is far too broad. It would require preemption of any generally applicable tax that happens to fall on any activity in which ERISA plans engage. Sales taxes, real estate taxes, unemployment taxes and gasoline taxes all "reach into the plan's coffers to siphon off monies" (Resp. Br. 16) and would be preempted under this analysis.[2] Indeed, the

[1] References to the Fund's brief are cited as (Resp. Br. __).

[2] Under this theory no medical center income may be taxed. Yet the Fund has not challenged the imposition of the tax on non-patient care related income such as medical records fees, supplier rebates, and proceeds from the sale of scrap (Resp. Br. 7).

Fund itself eventually concedes that these types of generally applicable taxes do not in fact "relate to" plans that pay them (Resp. Br. 31).

II. A GENERALLY APPLICABLE TAX ON HOSPITAL INCOME DOES NOT RELATE TO AN ERISA PLAN WHEN PLAN PAYMENTS ARE THE SOURCE OF HOSPITAL INCOME

The Fund then proffers a narrower theory, claiming that the application of a *Travelers* methodology leads to the conclusion that the HFA relates to the Fund. The Fund attempts to distinguish this case from the surcharges upheld in *Travelers* on two grounds. First, the Fund asserts that there is a clear Congressional intent to shield ERISA plans from state taxation, as opposed to state healthcare regulation. Second, the Fund claims that the HFA directly assesses contributions and other benefit payments made by ERISA plans and plan participants and, thus, interferes with the essential purpose of the plan. The first argument ignores the statutory language of ERISA that applies the same "relates to" test to state tax laws as to any other state law. The second argument misconstrues the HFA that assesses hospital income, not plan benefits.

A. State Tax Laws Are Treated As Any Other State Law for Purposes of ERISA Preemption

The Fund's attempt to distinguish the HFA from the surcharges in *Travelers* on the basis that it is a tax is both factually and legally unsound. As a factual matter, the HFA cannot be distinguished from the surcharges in *Travelers*.[3] Both

[3] The HFA is virtually indistinguishable from the 9% assessment upheld in *Travelers*. The 9% is an assessment on aggregate hospital costs imposed upon Health Maintenance Organizations ("HMOs") and is remitted by HMOs to the State's general fund. The HFA is imposed upon "gross receipts" and is remitted by hospitals to the State's general fund. Neither the HFA nor the 9% assessment is imposed upon plans. The 9%

the 9% and 11% surcharges in *Travelers* were taxes. Like the HFA, both raised revenue for the State's general fund. In fact, this Court noted in *Travelers* that the lower courts had considered the surcharges to be taxes for purposes of the Tax Injunction Act, 28 U.S.C. § 1341. 115 S. Ct. 1671, 1675 n. 4. Like the HFA, the surcharges also had healthcare related purposes.[4] Moreover, taxes, like healthcare regulation, are a traditional exercise of state authority. Indeed, they are the "lifeblood of government." *Franchise Tax Board of Cal. v. U.S. Postal Service*, 467 U.S. 512, 523 (1984) (quoting *Bull v. United States*, 295 U.S. 247, 259 (1935)).

The Fund's reliance on the HFA's status as a tax is also legally unsound. The standard for ERISA preemption of state tax laws is no different from the standard for ERISA preemption of any other state law. Tax laws are preempted to the extent they "relate to" plans. The Fund acknowledges this (Resp. Br. 25-26). The Fund's reliance upon section 514(b)(5)(B)(i) of ERISA, as indicating some special Congressional concern that state tax laws be preempted, is misplaced. This section provides that "[n]othing in subparagraph (A) shall be construed to exempt from subsection (a) . . . any State tax law relating to employee benefit plans." 29 U.S.C. § 1144(b)(5)(B)(i). Subparagraph A provides an exemption from ERISA preemption to the Hawaii PrePaid Health Care Act. Thus, section 514 (b)(5)(B)(i) is only an exception to the exemption from ERISA preemption accorded to the Hawaii act in section 514 (b)(5)(A), 29 U.S.C. § 1144 (b)(5)(A).

assessment is imposed upon HMOs and the HFA is imposed upon hospitals. The effect of both assessments upon ERISA plans is identical. The HFA, like the 9% assessment, increases the cost of providing healthcare benefits.

[4] The 9% assessment was imposed upon HMOs to encourage them to enroll medicaid recipients in an attempt to decrease medicaid costs. The 11% was imposed upon the hospital bills of commercial insureds in an effort to support Blue Cross's open enrollment policy. *See Travelers*, 115 S. Ct. at 1674.

Moreover, by using the same "relates to" language, Congress indicated its clear intent that state tax laws be treated like any other state law for purposes of ERISA preemption.[5]

The hospital assessment at issue here differs significantly from the laws involved in the tax cases relied upon by the Fund. Unlike the tax at issue here, in those cases state taxes or assessments that were directed specifically at ERISA plans were held to be preempted. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 502 U.S. 981 (1991) (state law that expressly imposed a 2.5% tax on claims and benefits paid under plans and on plan administrators' fees is preempted); *General Motors Corp. v. California Bd. of Equalization*, 815 F.2d 1305 (9th Cir. 1987), *cert. denied*, 485 U.S. 941 (1988) (tax computed on the basis of benefits paid by self-insured plans relates to plans because reference to plan activities is unavoidable); *Birdsong v. Olson*, 708 F. Supp. 793, 798 (W.D. Tex. 1989), *appeal dismissed*, 901 F.2d 1270 (5th Cir. 1990) (the same law as was at issue in *E-Systems* is preempted); *National Carriers' Conference Comm. v. Heffernan*, 454 F. Supp. 914 (D. Conn. 1978) (law that required ERISA plans to pay a tax on amounts paid as benefits is preempted because it is specifically directed at plans). These cases fit within the Court's holdings which have preempted state laws which refer to, are predicated upon, or which function only through the existence of, ERISA plans. *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990).

State tax laws of general applicability, like the tax at issue here, which happen to catch employee benefit plans within their wide sweep, have not been preempted. *See Thiokol Corp., Morton International, Inc. v. Roberts*, 76 F.3d 751,

[5] The legislative history of this section is recounted in detail in *Retirement Fund Trust of Plumbing v. Franchise Tax Board*, 909 F.2d 1266 (9th Cir. 1990), which concluded that the same "relates to" test of preemption that applies to state laws generally applies also to state tax laws.

753-57 (6th Cir. 1996), *petition for cert. filed*, 64 U.S.L.W. 3008 (U.S. May 23, 1996) (No. 95-1913) (tax which requires businesses to include within their tax base all compensation, including payments to ERISA plans, is not preempted by ERISA); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 554 (6th Cir. 1987) (municipal ordinance which imposes a 2% tax on all income earned by all residents, including ERISA plan contributions, is not preempted. Despite the argument that it had a direct effect on the funding of ERISA plans, the ordinance was a neutral tax of general application taxing all income regardless of its ultimate disposition).

The Fund mischaracterizes the State's argument concerning laws of general applicability. The State does not claim that all laws of general applicability are immune from ERISA preemption. Rather, the State acknowledges that laws of general applicability that dictate or restrict plan administration or benefit structure may relate to plans. Laws that are specifically directed at employee benefit plans, *Mackey v. Lanier Collection Agency and Serv., Inc.*, 486 U.S. 825, 830 (1988), or that depend upon the existence of employee benefit plans, *Ingersoll-Rand*, 498 U.S. 133, also relate to plans.

Nor, contrary to the Fund's argument (Resp. Br. 20), does the State claim that laws with only an economic impact on plans are immune from preemption. A law with only an economic impact on plans nevertheless "relates to" plans when it targets ERISA plans, *Greater Washington Bd. of Trade*, 506 U.S. 128; *Mackey*, 486 U.S. 830, when it depends upon the existence of ERISA plans, *Ingersoll-Rand*, 498 U.S. 133, or when its economic effect upon a plan is so "acute" that it effectively "forces an ERISA plan to adopt a certain scheme of substantive coverage or effectively restricts its choice of insurers," *Travelers*, 115 S. Ct. at 1683.

Many of the Fund's arguments in support of preemption of the HFA under a *Travelers* analysis are, in fact, identical to arguments rejected by this Court in *Travelers*. Thus, the arguments that the HFA relates to the Fund because its economic impact will deplete plan assets (Resp. Br. 22), will implicate interstate uniformity by varying the cost of benefits from state to state (Resp. Br. 21), and will provide an economic incentive to restructure administrative proceedings (Resp. Br. 21), have already been rejected by this Court. *See* 115 U.S. at 1679-80.

The Fund's argument that the application of the HFA to its medical centers is in violation of section 302 of the Labor Management Relations Act of 1947, 29 U.S.C. § 186, and section 403(c)(1) of ERISA, 29 U.S.C. § 1103(c)(1), commonly known as the exclusive benefit rule, is unavailing. The argument would apply equally to all taxes. The suggestion that the payment of healthcare taxes is in violation of the exclusive benefit rule has been rejected by every Court of Appeals that has addressed the issue. *See Boyle v. Anderson*, 68 F.3d 1094 (8th Cir. 1995), *cert. denied*, ___ U.S. ___, 116 S. Ct. 1226 (1996); *New England Health Care Employees Union, District 1199 v. Mount Sinai Hospital*, 65 F.3d 1024, 1032 (2d Cir. 1995); *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 996 F.2d 1179, 1196 (3d Cir.), *cert. denied*, 510 U.S. 944 (1993).

In the end, the Fund's argument that the HFA relates to plans because it is a tax begs the question. The Fund's claim that the HFA relates to plans, and is distinguishable from the surcharges in *Travelers*, is squarely based upon the fact that the HFA is a tax, and not on a claim that the HFA affects plans differently from the surcharges upheld in *Travelers*. Taxes are preempted only if they "relate to" plans. Thus, the mere fact that a law imposes a tax on plans cannot alone establish the claim that the law "relates to" plans.

B. The HFA Assesses Hospital Income, Not ERISA Plan Benefits

The Fund also argues that the HFA relates to ERISA plans, and is distinguishable from the surcharges upheld in *Travelers*, because it directly taxes contributions and other payments for health care benefits. This characterization misconstrues the HFA and its effect on plans. The HFA is not an assessment imposed upon employer contributions. Nor is it a tax on benefits paid by ERISA plans. It is a tax on hospital income. Despite the Fund's characterization, it is unable to articulate a coherent theory under which the HFA would be preempted as applied to patient care income received by its medical centers, but not preempted as applied to patient care income that any non-fund owned hospital can trace to an ERISA plan.

The HFA is an assessment imposed upon hospitals measured by hospital receipts "for or on account of hospital and health related services," regardless of source. It was not designed to tax ERISA plans or ERISA benefit payments. Rather, the HFA covers the Fund's medical centers only because they come within the wide sweep of the covered class of "hospitals." Payments to the medical centers for patient care services are subject to the assessment only because they fall within the broad definition of "gross receipts." A payment to a hospital from an ERISA plan may constitute a benefit to the plan participant on whose behalf the payment is made. To the ERISA plan that pays it, the payment may constitute the payment of benefits. But to the hospital, the taxed entity, it is simply income.

The laws at issue in *Travelers* set hospital rates for all patients, imposed surcharges on certain rates, and imposed an assessment on HMOs. N.Y. Pub. Health Law §§ 2807-c(1)(a), (b), (c), 2807-c(2-a). Their effect on ERISA plans is identical to that of the HFA. First, none of these laws applies to the plans themselves. Second, when ERISA plans provide hospital care benefits to their participants, the HFA, like the laws

at issue in *Travelers*, may increase the cost of providing such benefits to plans.

This analysis is not affected by the fact that an ERISA plan may own and operate a medical center subject to the assessment. If the HFA can be characterized as a tax "on contributions and other payments for healthcare benefits provided by ERISA plans" (Resp. Br. 10), that characterization is applicable anytime any ERISA plan pays money to any hospital on behalf of a plan participant. Ownership of the hospital is irrelevant to this characterization. The Fund itself does not differentiate between income the medical centers receive from employers who participate in its own plan and patient care income from other plans. Instead, the Fund's position is that ERISA preempts the HFA even when the assessed income can be traced to ERISA plans unrelated to the Fund (Resp. Br. 7,8). Thus, according to the Fund, payments from the PPGU fund, which is unrelated to the NYSA fund, are preempted from being included in assessable income. The Fund also argues that payments from workers' compensation carriers, who are also third parties to the Fund, cannot be included in assessable income. Yet, with regard to these entities, the Fund's medical centers operate no differently than any other non-fund owned hospital. They provide medical services for which they receive payments that constitute income to the centers.

All hospitals receive a large portion of their income for patient care services from ERISA plans. The only difference between this case and a case involving a hospital not owned by an ERISA plan is the portion of the hospital's income that is derived from ERISA plan payments. In this case, all assessable income from "patient care services" comes from ERISA plans, either the PPGU plan, the NYSA plan, or workers' compensation carriers. In the case of a hospital open to the general public, income will come from medicaid payments, medicare payments, self-insured ERISA plans, insured ERISA plans, non-ERISA employee benefit plans, private insurance

and individuals' payments. However, since 88% of non-elderly Americans get their health insurance through their employer,[6] a very large portion of any hospital's income could be characterized as payments and contributions which are intended to pay for ERISA plan participants' medical benefits.

Moreover, the effect of the HFA on the ERISA plans which pay for medical benefits is the same whether or not a hospital is owned by an ERISA plan. The PPGU plan, which makes payments to the Fund's medical centers, the NYSA plan employers, which send contributions to the medical centers, as well as all the ERISA plans that make payments to non-fund owned hospitals, are economically affected by the HFA.

III. A GENERALLY APPLICABLE TAX ON HOSPITAL INCOME DOES NOT RELATE TO AN ERISA PLAN SIMPLY BECAUSE THE PLAN OWNS THE HOSPITAL

Relying on section 3(1) of ERISA, 29 U.S.C. § 1002(1), which defines a plan as an entity whose purpose is to provide healthcare benefits "through the purchase of insurance or otherwise," the Fund argues that its ownership of the medical centers distinguishes this case from *Travelers*. According to the Fund, "[i]n dispensing care and treatment at its clinics the Fund is engaging in the very activity" that defines it as an ERISA plan (Resp. Br. 24). Thus, the Fund argues, it does not take "Jamesian metaphysics" to see that *all* state regulation of healthcare relates to the plan when an ERISA plan provides healthcare benefits in-kind (Resp. Br. 31-32). This theory of ERISA preemption would free ERISA plans from state regulation whenever they opted to provide any benefit in-kind. Nor, under this theory, can the Fund distinguish the HFA from

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[6] *See The Travelers Insurance Co. v. Cuomo*, 14 F.3d 708, 711 (2d Cir. 1994), *rev'd sub nom. New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. ___, 115 S. Ct. 1671 (1995).

other generally applicable taxes such as unemployment taxes imposed upon its employment of doctors, or sales taxes imposed upon its purchase of medical supplies.

ERISA defines a plan as a program whose purpose is to provide certain benefits. By definition, benefits are separate and distinct from plans. A benefit is not magically transformed into a plan when a plan chooses to provide it in-kind. For example, when plans provide benefits "through the purchase of insurance," not all operations of the insurance company become part of the plan. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 741 (1985). When plans provide benefits "otherwise" through HMOs, which also provide medical care in-kind, not every aspect of the provision of medical care implicates ERISA preemption. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

In *Travelers*, the HMOs made arguments concerning their relationship to ERISA plans quite similar to the Fund's argument in this case. There the HMOs relied upon the statute's "otherwise" language to argue that when a plan contracts with an HMO which provides medical care, the HMO is the mechanism through which the plan "otherwise" provides benefits. The HMO, therefore, is an integral part of the plan. The HMOs argued that they were immune from state regulation because there is a "confluence between the employee benefit plan and the HMO which is the entity that is actually providing for [the] participants . . . the medical, surgical or hospital care set forth in the statute." Brief for Respondents New York State Health Maintenance Organization Conference *et al.* at 20, submitted in *New York State Conference of Blue Cross and Blue Shield Plans v. The Travelers Insurance Co.*, 514 U.S. ___, 115 S. Ct. 1671 (1995) (Nos. 93-1408, 93-1414, 93-1415). This Court rejected these arguments *sub-silentio*.

The "relate to" standard urged by the Fund, which would preempt all laws that affect a plan's provision of benefits, provides no limitation on the scope of ERISA preemption.

Employee benefit plans may not engage in activities unrelated to the provision of benefits. They cannot, for example, operate amusement parks or shoe stores since ERISA requires all assets be used for the exclusive purpose of providing benefits to participants or deferring reasonable administrative expenses. 29 U.S.C. § 1103(c)(1). This is true whether or not a plan provides benefits in-kind. Thus, under the Fund's theory, all plan activities are shielded from state regulation. Further, while the Fund admits that it is subject to state law when it is engaging in activities that "are not peculiar to employee benefit plans but are carried on by other private entities" (Resp. Br. 31), when a plan does provide healthcare, day care, or prepaid legal services in-kind, it is in fact engaging in activities in which many other private entities engage. This contradiction renders the Fund's proposed standard meaningless.

In order to provide benefits through its medical centers, the Fund must hire employees, including nurses, doctors and medical records clerks. It must purchase medical supplies and pay utility bills for necessary electricity. All of these functions are essential to the operation of a hospital and, therefore, under the Fund's theory, affect the plan as a plan (Resp. Br. 31). Yet, the Fund concedes that when a plan operates as an employer or a purchaser of goods and services it may be regulated by the State. State unemployment taxes on plan doctors, sales taxes on syringes, gasoline taxes on plan-owned ambulances, and minimum wage requirements for medical records clerks affect the provision of benefits to the same extent as staffing requirements and medical waste regulations. Once again, the Fund's test casts too wide a net and is unable to distinguish functions which are peculiar to employee benefit plans from those in which many other entities engage.

Perhaps realizing that a test for ERISA preemption that invalidates all state laws that affect a plan's in-kind provision

of benefits is untenably broad,[7] the Fund finally retreats from this position. Instead, the Fund offers a new test of preemption: although all regulation "relates to" the in-kind provision of benefits provided by ERISA plans, only those laws that do not involve the historic police powers of the state are preempted (Resp. Br. 32). The Fund places tax laws outside this arena, but refuses to speculate as to where other state laws would fall. The Fund frankly concedes that such a test requires a case-by-case determination (Resp. Br. 32). This test ignores the statutory language of ERISA, which treats tax laws like all other state laws. Instead, it substitutes an inquiry tailored to the facts of this case for statutory analysis.

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[7] Such a test would displace all state regulation anytime a plan opted to provide healthcare, day care or legal services benefits in-kind. Thus, despite the Fund's attempt to make light of the State's concern about "unqualified nurses, unprotected children, unethical lawyers and unembalmed bodies" (Resp. Br. 30), it is a real concern under the Fund's theory.

CONCLUSION

For the reasons set forth here and in the State's main brief, the Court should reverse the judgment below.

Dated: New York, New York
January 28, 1997

Respectfully submitted,

DENNIS C. VACCO
Attorney General of the
State of New York
120 Broadway
New York, New York 10271
(212) 417-8707

BARBARA G. BILLET
Solicitor General

PETER H. SCHIFF
Deputy Solicitor General

DANIEL F. DE VITA
Assistant Attorney General
in Charge of Labor Bureau

M. PATRICIA SMITH*
Assistant Attorney General
of Counsel

* *Counsel of Record*

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

WALTER DELLINGER
Acting Solicitor General
EWIN S. KNEEDLER
Deputy Solicitor General
JAMES A. FELDMAN
Assistant to the Solicitor General
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

J. DAVITT MCATEER
Acting Solicitor of Labor
ALLEN H. FELDMAN
Associate Solicitor
NATHANIEL I. SPILLER
Deputy Associate Solicitor
JUDITH D. HEIMLICH
Attorney
Department of Labor
Wasington, D.C. 20210

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QUESTION PRESENTED

Whether a state tax on the "gross receipts received from all patient care services and other operating income" of hospitals licensed to operate in the State "relate[s] to" employee welfare benefit plans within the meaning of Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a), and is thus preempted, insofar as the tax applies to the income of medical centers owned and operated by an ERISA plan.

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In the Supreme Court of the United States

OCTOBER TERM, 1996

No. 95-1594

BARBARA A. DE BUONO, NEW YORK STATE COMMISSIONER OF HEALTH, ET AL., PETITIONERS

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, ETC., ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

INTEREST OF THE UNITED STATES

This case presents questions concerning the scope of the preemption provision of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001-1169; see 29 U.S.C. 1144. The Secretary of Labor is primarily responsible for enforcing and administering Title I of ERISA. See 29 U.S.C. 1002(13), 1136(b). The United States therefore has a substantial interest in the resolution of the question presented. In response to the Court's invitation, the United States filed a brief at the petition stage of this case urging that certiorari be granted.

STATEMENT

1. In 1990 New York State enacted a tax, known as the Health Facility Assessment (HFA), in order to raise revenue and avoid reductions in the State's Medicaid program. Pet. App. 7a; C.A. App. 46, 51, 56, 59. With certain exceptions not relevant here, the assessment is imposed on all "[h]ospitals" operating in the State. The statute defines the term "hospital" to include a broad range of facilities that provide health care services under the supervision of a physician or dentist, and expressly encompasses a "diagnostic center" and a "treatment center." N.Y. Pub. Health Law §§ 2801(1), 2807-d(1)(a) (McKinney 1993). The assessment is calculated as a percentage of the hospital's "gross receipts received from all patient care services and other operating income." *Id.* § 2807-d(1)(a).[1] The percentage differs for three types of hospitals, see *id.* § 2807-d(2)(a) to (c), but is assessed at 0.6% for diagnostic and treatment centers.

The law requires hospitals to make monthly payments of the assessment to the health commissioner or her designee, who remits the accumulated monies to the State's general fund. N.Y. Pub. Health Law § 2807-d(1)(a), (5), (7)(d) and (9) (McKinney 1993); see C.A. App. 60. Hospitals must also submit quarterly reports, and a certified annual report, of their gross receipts that are subject to the tax.

[1] Receipts from "patient care services" refers to "all monies received for or on account of hospital or health-related services," including preadmission, out-patient, in-patient, and post discharge care, and items such as nursing service, ambulance service, laboratory service, medical social service, drugs, supplies, and room and board. N.Y. Pub. Health Law §§ 2801(4)(a) and (b), 2807-d(3)(c) (McKinney 1993). "Operating income" includes "monies received for or on account of such revenue sources as investment income, parking lots, cafeterias, gift shops and rental income," with certain exclusions. N.Y. Pub. Health Law § 2807-d(3)(d) (McKinney 1993); see C.A. App. 65.

N.Y. Pub. Health Law § 2807-d(7)(a) and (b) (McKinney 1993); see C.A. App. 60.

2. Respondents are the trustees of the NYSA-ILA Medical and Clinical Services Fund (Fund). The Fund is a labor-management trust governed by Section 302 of the Labor Management Relations Act of 1947, 29 U.S.C. 186. The Fund was established pursuant to an Agreement and Declaration of Trust and Plan and collective bargaining agreements between the New York Shipping Association, Inc., and the International Longshoremen's Association covering longshore employment in the Port of New York and New Jersey. Pet. App. 7a; C.A. App. 19. The Fund administers a self-insured, ERISA-covered multi-employer welfare benefit plan, see 29 U.S.C. 1002(1) and (37); 26 U.S.C. 414(f), that provides medical, dental and other health services on an outpatient basis through three medical centers that it owns and operates. Pet. App. 7a. The two centers at issue here are located in New York and are licensed by the State to operate as diagnostic and treatment centers. Pet. 4; see N.Y. Public Health Law § 2805 (McKinney 1993); C.A. App. 43, 57, 83.

The centers principally serve longshore workers and retirees (and their dependents) whose labor contracts entitle them to receive health care at the centers. C.A. App. 78. The centers also provide services to members of other ILA locals who are employed by non-longshore employers ("outside employers") and whose contracts also entitle them to health care at the centers, *ibid.*; to members of the Port Police and Guards Union (PPGU) which, through its own ERISA-covered welfare plan (the NYSA-PPGU Welfare Fund), contracts with the NYSA-ILA Fund for the treatment of its members on a fee-for-service basis at the centers, C.A. App. 79, 81; and to local union officers and employees, *ibid.*

The centers receive income from a variety of sources. First, they receive payments directly from Fund participants for annual registration fees and prescription co-payments. C.A. App. 76, 82, 143-144. Second, they receive payments from workers' compensation insurance carriers for services rendered to Fund participants injured on the job. C.A. App. 76, 82. Third, each of the centers receives contributions from nearby employers calculated on the basis of hours worked by Fund participants, as provided by labor contracts.[2] C.A. App. 76, 81. Fourth, the centers receive payments from the NYSA-PPGU Welfare Fund for services rendered to its participants on a fee-for-service basis. *Ibid.* Under the New York law, all of those categories of income constitute receipts from patient care services, and the HFA has been assessed against them. A fifth category of income—weekly remittances from the Fund for operating expenses on an as-needed basis—has not been subject to the assessment. C.A. App. 80.[3]

From January through November 1991, the centers filed reports and paid the 0.6% assessment applicable to diag-

[2] Although some employers send their contributions directly to the closest medical center, others (especially those who operate at more than one location) send their contributions to the Fund, which in turn funnels the money on an as-needed basis to the medical centers. C.A. App. 80-81; see note 3, *infra*.

[3] The remittances derive from employer contributions to the Fund for Fund participants and contributions for local union officers and employees based on hours of work. C.A. App. 80-81. The Fund maintains that those remittances are akin to a grant that is nonassessable income under the New York law, Pet. 4 (citing C.A. App. 84), and the State has not attempted to apply the HFA to those monies. Pet. App. 8a; see *id.* at 13a. The assessability of remittances from the Fund to the centers is therefore not at issue in this case. *Id.* at 8a. Application of the assessment to operating income derived from such activities as records reproduction fees, which respondents do not challenge, is also not at issue. *Id.* at 9a.

nostic and treatment centers on revenues the centers received for patient care services. Pet. App. 8a; see C.A. App. 143, 138.[4] Thereafter the Fund placed its assessments into escrow and ceased filing reports. Pet. App. 8a; C.A. App. 21-22. Beginning in 1992, payment of registration fees by Fund participants and service fees by the NYSA-PPGU Welfare Fund was redirected to the Fund instead of to the centers. Pet. App. 8a; C.A. App. 86.

3. In 1992 respondents brought this action to invalidate and enjoin enforcement of the HFA on the ground that it is preempted by Section 514(a) of ERISA, 29 U.S.C. 1144(a), "insofar as [the HFA] imposes a levy on contributions and payments for health care benefits provided by the Fund." Pet. App. 9a.[5] ERISA's preemption clause provides that ERISA supersedes all state laws that "relate to" an ERISA plan. 29 U.S.C. 1144(a).

On cross motions for summary judgment, the district court held that ERISA does not preempt the HFA.[6] Pet. App. 19a. Relying on *Aetna Life Insurance Co.* v. *Borges*, 869 F.2d 142 (2d Cir.), cert. denied, 493 U.S. 811 (1989), the district court reasoned that the HFA is a tax law of general application because "it is not specifically directed at ERISA plans but applies to all health care facilities." Pet. App. 21a. The court observed that the tax "does not interfere with the calculation of benefits" or with "the determination of an employee's eligibility for benefits,"

[4] For that period the Fund paid $7,066 on assessable income of $1,177,670 (patient receipts and operating income). Pet. App. 8a; C.A. App. 84-85.

[5] Petitioners also sought "compensatory damages equal to the amounts paid to" the State, plus interest, costs and fees. C.A. App. 23.

[6] The district court did not reach the State's defenses under the Tax Injunction Act, 28 U.S.C. 1341, and the Eleventh Amendment. Pet. App. 19a.

and that the HFA's "impacts on benefit plans are incidentally economic resulting only in the need for administrative and accounting procedures to comply with the law." *Ibid.* The court also concluded that the economic impact of the 0.6% assessment is not substantial. *Id.* at 22a.

4. The court of appeals reversed. Pet. App. 6a-14a. It rejected the district court's conclusion that the HFA is a law of general application, because the HFA "does not apply broadly to every sector of society" in the State, but rather "targets only the health care industry," which, "by definition, [is] the realm where ERISA welfare plans must operate." *Id.* at 12a. Because the HFA "operates as an immediate tax on payments and contributions which were intended to pay for participants' medical benefits," the court stated, it "directly affects the Fund in its principal role" as a provider of health care benefits to plan participants and beneficiaries. *Ibid.* The court thus concluded that the HFA "relates to" the Fund because it "depletes those assets earmarked for the provision of health care benefits," and would cause the plan either to reduce benefits or increase charges. *Ibid.* In the court's view, those consequences would "detrimentally affect the central mission and purpose of the Fund," and therefore are not "remote or tenuous." *Ibid.*

Further, the court stated, it makes no difference that the Fund could avoid the HFA by "restructuring its finances so that funds formerly remitted by plan participants and employers directly to the medical centers would be remitted to the Fund which would subsequently transfer them to the centers"; in the court's view, state laws "that force plans to change their traditional methods of administration or to adopt different methods on a state-by-state basis" are preempted by ERISA. Pet. App. 13a. Finally, the court concluded, a state law does not escape

ERISA preemption merely because its economic impact on ERISA plans is de minimis. *Id.* at 14a.

5. This Court granted the State's petition for a writ of certiorari, vacated the judgment of the court of appeals, and remanded the case for further consideration in light of its intervening decision in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 115 S. Ct. 1671 (1995). Pet. App. 5a. This Court held in *Travelers* that New York statutes imposing 9%, 11% and 13% surcharges on hospital care paid for by health maintenance organizations and commercial insurers did not "relate to" ERISA plans within the meaning of Section 514(a), and thus were not preempted. 115 S. Ct. at 1674. Determining that the surcharge statutes did not "make 'reference to'" ERISA plans, the Court analyzed whether they nevertheless had a "connection with" the ERISA plans. *Id.* at 1677; see *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). The Court observed that ERISA preempts state laws that "mandate[ ] employee benefit structures or their administration" or "provid[e] alternative enforcement mechanisms" for ERISA claims. 115 S. Ct. at 1678. Unlike those effects, the Court reasoned, the surcharge statutes had only "an indirect economic effect on choices made by insurance buyers, including ERISA plans." *Id.* at 1679. The Court noted that the surcharge statutes did not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." *Ibid.* Nor, the Court reasoned, did the "indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform benefit package." *Ibid.*

6. On remand from this Court, the Second Circuit adhered to its original decision in this case. Pet. App. 1a-4a. The court of appeals observed that the surcharges in *Travelers* were imposed not "on ERISA plans themselves,

but on insurance carriers providing health insurance coverage to the plans and their beneficiaries." *Id.* at 3a. Those surcharges, the court stated, "raised costs to the patient, who remained liable for the balance of any bill" not paid by insurance or an ERISA plan. *Ibid.* Accordingly, the court stated, the surcharges '"operat[ed] as an indirect source of merely economic influence'" on plan decisions. *Ibid.*, quoting *Travelers*, 115 S. Ct. at 1680. The court distinguished the HFA on the ground that "there is no third party between the plan and the tax imposed pursuant to the HFA," so that the HFA "depletes the Fund's assets directly." Pet. App. 3a-4a. Thus, the court concluded, "[n]othing in *Travelers* undermines our reliance on the HFA's direct economic impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of preemption." *Id.* at 4a.[7]

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[7] The court of appeals' analysis on remand in the instant case was foreshadowed by its decision on remand in *Travelers*. This Court had remanded the case to the court of appeals to determine whether the 13% surcharge applicable to hospital bills incurred by members of "self-insured funds" was preempted. 115 S. Ct. at 1675 n.4. On remand, the Second Circuit held that the 13% surcharge did not relate to "self-insured funds." *Travelers Ins. Co.* v. *Pataki*, 63 F.3d 89, 93-94 (1995). The court distinguished the HFA from the 13% surcharge on the ground that the HFA directly depletes plan assets, whereas self-insured plans are "not directly liable for the surcharge." *Id.* at 94. The court questioned, however, whether it "should continue to distinguish between laws that directly deplete ERISA plans' assets and laws that only indirectly do so." *Ibid.* In the court's decision on remand in the instant case, it did not cite to its remand decision in *Travelers*.

INTRODUCTION AND SUMMARY OF ARGUMENT

Section 514(a) of ERISA provides that, with certain exceptions not relevant here, ERISA "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan" covered by the Act. 29 U.S.C. 1144(a). Because the key term "relate to" is of indefinite scope, the application of that provision has posed difficult problems, and this Court has therefore adjudicated numerous cases in recent years in which parties have claimed that Section 514(a) preempts a variety of state laws insofar as they are applied to or affect ERISA plans. As a result of those cases, certain key principles concerning the scope and limits of the term "relate to" can now be summarized in a more concrete form than was hitherto possible, thus providing additional guidance to the lower courts and obviating some of the confusion that has been present in this area.

Congress intended that the regulation of ERISA-covered employee benefit plans be exclusively an area of federal concern. Therefore, in areas where ERISA itself provides law or remedies, Congress intended that Section 514(a) broadly preempt the field of state regulation. Moreover, even in areas where ERISA does not itself provide law or remedies, Congress's occupation of the field precludes the States from attempting to impose their own ideas—regardless of how salutary—regarding the structure and administration of benefit plans. For that reason, state laws that specifically refer to ERISA plans are also preempted. Beyond that area, this Court's cases establish that Congress intended a further area of preemption, since it intended to leave to the private parties involved— primarily the employer and employee—the basic substantive decision regarding what benefits should be provided.

Thus, state laws that require employers to offer particular benefits are also preempted (unless preserved by the savings clause, 29 U.S.C. 1144(b)).

There is no basis for extending preemption under Section 514(a) to state laws of general applicability that do not fall within any of the above categories. ERISA plans frequently choose to provide benefits by entering an area of commerce or activity traditionally governed by state laws that are applicable to many others who also operate in that area. By conducting activities in the regulated area, the ERISA plan subjects itself to the same state laws that governs all other actors within the State. Thus, ERISA plans that offer medical services remain subject to generally applicable, plan-neutral state regulation of (and taxation of) medical care, just as ERISA plans that offer other kinds of services remain subject to generally applicable, plan-neutral state regulation of those services. A State may, through such laws of general application, regulate or tax an activity in a way that adds to its costs or limits the way in which the activity may be conducted in the State by anyone, including plans, but it cannot direct employers to provide a particular plan benefit or prohibit them from providing a benefit that is permitted outside ERISA plans.

Under the foregoing principles, the Second Circuit's decision holding the HFA preempted must be reversed. The HFA tax does not prescribe any law in any field for which ERISA itself furnishes governing law, since ERISA itself contains no provision for the regulation of hospitals. Nor does the HFA tax make any reference to ERISA plans or otherwise treat them differently from all other owners of hospitals in the State. Nor does the HFA tax require or prohibit employers or plans to offer any specific employee benefits. In those circumstances, because the HFA is a

tax of general applicability, and because it undoubtedly operates in an area of traditional state regulation, it does not "relate to" ERISA plans. The HFA relates, rather, to the provision of hospital services in New York. Accordingly, it is not preempted by Section 514(a).

The Second Circuit erred in holding that the fact that the ERISA plan (or, more precisely, the hospital that the plan owned) must directly pay the tax is sufficient to warrant preemption. ERISA preemption is not limited to direct state regulation; it applies, for example, to all state laws that "purport[] to regulate, directly or indirectly," ERISA plans. 29 U.S.C. 1144(c)(2). Nor do this Court's decisions, which have held some "indirect" state regulation preempted while permitting some "direct" state regulation to stand, make the characterization of a state law as "indirect" or "direct" dispositive of the preemption issue. Finally, if the Second Circuit's theory that "direct" regulation is necessarily preempted were correct, virtually every state regulation of health care—in addition to regulation of legal services, day care for children, and other areas of traditional state health and safety regulation—would be inapplicable to ERISA plans that choose to provide those services themselves rather than purchasing them from others. This Court held in *Travelers* that Congress "could not possibly have intended" to eliminate "myriad state laws in areas traditionally subject to local regulation." 115 S. Ct. at 1683. The Second Circuit's theory therefore must be rejected.

ARGUMENT

APPLICATION OF NEW YORK'S HOSPITAL FACILITY ASSESSMENT TO THE HEALTH CARE FACILITIES OPERATED BY RESPONDENTS IS NOT PREEMPTED BY SECTION 514(a) OF ERISA

A. Section 514(a) Of ERISA Does Not Preempt A Generally Applicable State Law In An Area Of Traditional State Regulation, So Long As The Law Does Not Operate In A Field In Which ERISA Itself Provides Governing Standards, Makes No Reference To ERISA Plans, And Does Not Require That Plans Or Employers Provide Any Particular Benefits

Section 514(a) of ERISA provides that, with certain exceptions not relevant here, ERISA "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan" covered by the Act. 29 U.S.C. 1144(a). This Court has addressed that provision numerous times in recent years in a variety of contexts. What has emerged from this Court's decisions are four basic propositions regarding the scope of ERISA preemption, each of which governs a distinct category of state laws challenged under Section 514(a). We do not contend that recognition of these categories would automatically resolve all of the difficult questions regarding ERISA preemption. But we believe that it is useful to distinguish the different sorts of cases that arise in order to identify the factors that determine the preemption issue in each class of cases.

1. *Where ERISA provides law governing an area, preemption of state law in that field is very broad.* Where ERISA itself provides governing legal standards, preemption under Section 514(a) is at its broadest. In those areas, ERISA's "deliberately expansive" language was "designed to 'establish pension plan regulation as

exclusively a federal concern.'" *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 46 (1987). Specifically, ERISA "imposes participation, funding, and vesting requirements on pension plans"; it "sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for both pension and welfare plans"; and it includes "a carefully integrated civil enforcement scheme that is one of the essential tools for accomplishing the stated purposes of ERISA." *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 137 (1990) (internal quotation marks omitted). Because ERISA therefore broadly governs the rights, duties, and remedies of plan participants and beneficiaries vis-a-vis plan fiduciaries and employers, state laws that also regulate those areas are preempted.

In *Ingersoll-Rand*, for example, this Court held preempted a state-law wrongful discharge action based on a claim that an employer discharged an employee to avoid contributing to the employee's pension plan. The court reached that conclusion in part because the state-law cause of action "conflicts directly" with the ERISA-created, exclusively federal cause of action under ERISA Section 502(a) and (e), 29 U.S.C. 1132(a)(3), (e). *Ingersoll-Rand*, 498 U.S. at 143; see ERISA § 510, 29 U.S.C. 1140 (prohibiting interference with rights protected under ERISA or a benefit plan). For similar reasons, the Court held in *Pilot Life Ins. Co.* that "common law causes of action * * * based on alleged improper processing of a claim for benefits under an employee benefit plan undoubtedly meet the criteria for pre-emption under § 514(a)" because they conflict with ERISA's exclusive civil enforcement remedies. 481 U.S. at 48; see 29 U.S.C. 1132(a).[8] In

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[8] *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), is governed by the same principles. In that case, the Court first concluded that "Congress expressly preserved the option of pension fund integra-

areas such as these, the existence of federal law precludes the States from applying their own law or creating their own causes of action, even if their own law or remedy is claimed to be supplementary to or supportive of the underlying goals of ERISA.

2. *Where ERISA itself does not provide governing legal standards, state laws specifically referring to ERISA plans are nonetheless preempted.* ERISA does not, however, "pre-empt only state laws dealing with the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like." *Shaw* v. *Delta Air Lines*, 463 U.S. at 98. Where ERISA itself does not provide law governing an area, state laws are still preempted if they refer to employee benefit plans and single them out for special treatment. For example, in *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829-830 (1988), this Court held that a state law exempting ERISA plans from generally applicable garnishment procedures was preempted by Section 514(a). The law's defect was that it "expressly refers to—indeed, solely applies to—ERISA employee benefit plans." 486 U.S. at 829. Similarly, i.. *District of Columbia* v. *Greater Washington Bd. of Trade*, 506 U.S. 125 (1992), the Court held preempted a local law requiring employers to provide employees receiving workers compensation with health insurance

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tion"—defined as the practice of determining benefits "by combining pension funds with other income streams available to the retired employees"—when it enacted ERISA. 451 U.S. at 514. The Court also noted that that practice had been sanctioned by a valid Department of Treasury regulation. 451 U.S. at 517-521. The Court concluded that the New Jersey statute at issue in that case was preempted "because it eliminates one method for calculating pension benefits—integration—that is permitted by federal law." 451 U.S. at 524. See also *FMC* v. *Holliday*, 498 U.S. 52 (1990) (ERISA preempts law barring plans from enforcing subrogation claims on benefits).

equivalent to "the existing health insurance coverage" provided by the employer to other employees. 506 U.S. at 130. Because the "existing health insurance coverage" was necessarily "a welfare benefit plan under ERISA," the Court held that the local law "specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is pre-empted." *Ibid.*; see also *Ingersoll-Rand*, 498 U.S. at 136; *FMC Corp.* v. *Holliday*, 498 U.S. at 59.[9]

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[9] The lower courts have uniformly held that state tax laws that are specifically directed at ERISA plans "relate to" plans. See *E-Systems, Inc.* v. *Pogue*, 929 F.2d 1100, 1101, 1103 (5th Cir.) (state law that imposed a 2.5% tax expressly on plan administrators' fees and on claims and benefits paid under a plan is preempted), cert. denied, 502 U.S. 981 (1991); *General Motors Corp.* v. *California Bd. of Equalization*, 815 F.2d 1305, 1309 (9th Cir. 1987) ("tax * * * computed on the basis of benefits paid by the [self-insured ERISA-covered] plans" relates to plans because "reference to plan activities in computing the tax is unavoidable"), cert. denied, 485 U.S. 941 (1988); *Birdsong* v. *Olson*, 708 F. Supp. 792, 798 (W.D. Tex. 1989) (preempting same law as in *E-Systems*), appeal dismissed, 901 F.2d 1270 (5th Cir. 1990); *National Carriers' Conference Comm.* v. *Heffernan*, 454 F. Supp. 914, 915 (D. Conn. 1978) (state law that required "group maintaining [the] plan" to pay annual tax of 2.75% on "amounts paid as benefits" is a law "specifically directed at such plans exclusively" and is preempted) (citation omitted).

By the same token, courts have recognized that state tax laws that do not accord special treatment to plans are not preempted. See *Thiokol Corp., Morton Int'l, Inc.* v. *Roberts*, 76 F.3d 751, 753, 754-755 (6th Cir. 1996) (2.35% state tax imposed on business tax base that included employers' payments to ERISA plans "has, at most, a tenuous, remote, or peripheral effect" that does not warrant preemption), petition for cert. pending, No. 95-1913 (filed May 23, 1996); *Retirement Fund Trust of Plumbing* v. *Franchise Tax Bd.*, 909 F.2d 1266, 1281 (9th Cir. 1990) (State's "tax levy procedure does not single out ERISA trusts" and is a "neutral law of general application"); *Firestone Tire & Rubber Co.* v. *Neusser*, 810 F.2d 550, 551, 554 (1987) (2% city tax imposed on earned income of city residents that included employee contributions for ERISA plan benefits is a "neutral tax of general application" that is not preempted).

State laws referring to and singling out ERISA plans are preempted because Congress intended in passing ERISA to leave to federal law the field of regulation of ERISA-covered employee benefits. As this Court has noted, the congressional sponsors of ERISA referred to "the reservation to federal authority [of] the sole power to regulate the field of employee benefit plans" as the "crowning achievement" of the ERISA legislation. *Shaw*, 463 U.S. at 99 (quoting 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent)); see also *ibid.* (quoting 120 Cong. Rec. 29,933 (1974) ("substantive and enforcement provisions of [ERISA] are intended to preempt the field for Federal regulations") (statement of Sen. Williams)). Although state laws of general applicability that "function[ ] irrespective of the existence of an ERISA plan," *Ingersoll-Rand*, 498 U.S. at 139, may not be preempted even though they may affect the operation of ERISA plans, see *infra* pp. 19-23, the States may not attempt *specifically* to regulate that field. Because a state law that refers to employee benefit plans intrudes the State into the field reserved to federal law by Congress, it is preempted.[10]

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[10] This Court has not had occasion to address the limits of the "reference to" analysis. If a state law that is *not* one of general applicability clearly is intended to target ERISA employee benefit plans and single them out for special treatment, but is drafted so as to avoid explicit reference to such plans, the law may still be preempted under this principle. On the other hand, where a purely verbal reference to ERISA plans in a state law of general applicability is necessary to ensure that ERISA plans are treated the same as a broad class of other entities within an area subject to state control, the state law may in some circumstances avoid preemption. See, *e.g.*, *Thiokol Corp., Morton Int'l.*, 76 F.3d at 756-761; *New England Health Care Employees Union, District 1199* v. *Mount Sinai Hospital*, 65 F.3d 1024, 1032 (2d Cir. 1995); *NYS Health Maintenance Org. Conference* v. *Curiale*, 64 F.3d 794, 799-801 (2d Cir. 1995); *United Wire, Metal & Machine Health & Welfare Fund* v. *Morristown Memorial Hosp.*, 995 F.2d 1179, 1192 n.6 (3d Cir.), cert. denied, 510 U.S. 944 (1993).

3. *Where ERISA itself does not provide law governing an area, state laws requiring or prohibiting provision by employers of certain employee benefits through ERISA plans are preempted.* ERISA preemption extends to an additional category of cases. Where ERISA itself does not provide federal law governing an area, state laws are still preempted if they require employers to provide a particular employee benefit through an ERISA plan. For example, in *Shaw* v. *Delta Air Lines*, the Court held that New York's Human Rights Law and its Disability Benefits Law "relate[d] to" ERISA plans because they required employee welfare plans to provide benefits for pregnancy. 463 U.S. at 97; see *Travelers*, 115 S. Ct. at 1678. Similarly, in *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985), Massachusetts implicitly conceded (and the Court readily assumed) that its law, which required any employee welfare "fund" that provided hospital benefits also to provide minimum mental health benefits, related to self-insured ERISA plans. *Id.* at 730 n.11, 735 n.14; see *Travelers*, 115 S. Ct. at 1680.[11]

The rule that emerges from *Metropolitan Life* and *Shaw* is that States cannot tell employers which, if any, welfare benefits to offer employees. As a result, employers operating in a number of States can offer benefits to their employees on a uniform basis across the country, thereby avoiding the "considerable inefficiencies" resulting from "[a] patchwork scheme of regulation" that could in turn "lead those employers with existing plans to

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[11] Although "related to" ERISA plans under Section 514(a), the minimum mental health benefit was nonetheless saved from preemption by operation of the ERISA "savings" provision for state laws of insurance. *Metropolitan Life*, 471 U.S. at 739-749; see 29 U.S.C. 1144(b)(2)(A).

reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987); see also *FMC Corp.* v. *Holliday*, 498 U.S. at 60 ("Application of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide."); *Travelers*, 115 S. Ct. at 1677-1678; *Shaw*, 463 U.S. at 105 n.25. By precluding States from requiring plans to provide particular health or other benefits, ERISA also permits employers to be certain that employees in a mandated-benefit State would not receive those benefits at the expense of employees in another State that did not mandate those benefits.

Finally, to permit States to dictate the level of benefits would be inconsistent with Congress's considered decision that ERISA "not mandate that employers provide any particular benefits." *Shaw*, 463 U.S. at 91; see also *Travelers*, 115 S. Ct. at 1674 ("[t]he federal statute does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans"); *Curtiss-Wright Corp.* v. *Schoonejongen*, 115 S. Ct. 1223, 1228 (1995) (ERISA does not "create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits.").[12] In reaching that conclusion, Congress determined that the public welfare would be maximized if the interested parties could tailor benefits packages to the financial resources that the

[12] Although ERISA does not "establish any minimum participation, vesting, or funding requirements for welfare plans as it does for pension plans," *Curtiss-Wright*, 115 S. Ct. at 1228, that omission was deliberate. Therefore, state regulation of those subject matters for welfare plans would also be inconsistent with ERISA, as it would be for pension plans.

employer wanted to make available and the needs that the employees most wanted to satisfy. To permit the States to intrude on that decision by mandating particular benefits would conflict with Congress's determination that such decisions should be left to the private sector.[13]

4. *Where an employer or ERISA plan chooses to provide benefits by engaging in an activity subject to state regulation, it is subject to that regulation.* Outside the areas outlined above, ERISA plans that choose to undertake activities in areas over which the States have undoubted regulatory (and taxing[14]) authority generally remain subject to that authority in the same way as other entities in the State.[15] This Court has long acted on the "assumption

[13] A state law prohibiting plans from providing a particular benefit would raise similar concerns. However, as discussed below, a plan-neutral prohibition on a regulated activity that applies equally to plans and non-plans would not be preempted.

[14] Section 514(b)(5)(B)(i) of ERISA provides that "any State tax law relating to employee benefit plans" is not "exempt from subsection (a)" of Section 514. 29 U.S.C. 1144(b)(5)(B)(i). The history of Section 514(b)(5)(B)(i) is recounted in *Retirement Fund Trust of Plumbing* v. *Franchise Tax Bd.*, 909 F.2d 1266 (9th Cir. 1990), which concluded that "Congress intended, when it enacted § 514(b)(5), that state tax laws should receive precisely the same analysis as other state laws. Only state tax laws that 'relate to' ERISA plans are preempted." *Id.* at 1280; accord *Birdsong* v. *Olson*, 708 F. Supp. 792, 797 (W.D. Tex. 1989) ("state tax laws related to employee welfare benefit plans are preempted"), appeal dismissed, 901 F.2d 1270 (5th Cir. 1990); *Northwest Airlines, Inc.* v. *Roemer*, 603 F. Supp. 7, 12 (D. Minn. 1984) ("Congress intended to preempt state tax laws insofar as they relate to employee benefit plans"). Neither the district court, nor the court of appeals in its original and remand decisions, referred to Section 514(b)(5).

[15] Thus, in this case the Fund, a self-insured welfare plan, chose to provide hospital care through a facility that it owns and operates. If the Fund had instead chosen to purchase hospital care from hospitals directly or from insurers that provide such coverage, this case would be analytically identical to *Travelers*. Indeed, because this case, unlike

that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Travelers*, 115 S. Ct. at 1676; see also *Metropolitan Life*, 471 U.S. at 740. Congress itself provided no substantive standards in ERISA governing medical care, day care centers, or prepaid legal services—to name just a few of the areas in which ERISA plans operate. See 29 U.S.C. 1002(1). Nothing in ERISA suggests that Congress intended that those areas should be entirely free of state regulation (and thus of *all* governmental regulation) whenever they happen to be provided in kind by an ERISA plan. See *Travelers*, 115 S. Ct. at 1683 (state regulation of medical care is "no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate").

In short, although Congress in enacting ERISA meant to establish plan regulation "as exclusively a federal concern," *Travelers*, 115 S. Ct. at 1677 (quoting *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)), Congress did not intend similarly to federalize the regulation of hospitals, lawyers, or day care centers. See, *e.g.*, *Harmon City, Inc.* v. *Nielsen & Senior*, 907 P.2d 1162 (Utah 1995) (legal malpractice claims against plan attorneys not preempted). Indeed, it would be extraordinary if a Congress that was intent on protecting the rights of plan participants and beneficiaries, see 29 U.S.C. 1001, in fact deprived those parties of the protection of traditional state regulation merely because the services ordinarily subject to that regulation were provided by ERISA plans. Such state

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Travelers, involves a tax that is imposed at a uniform rate and that therefore has *no* effect on a plan's decisions about how to provide medical care, the state assessment here has less of an impact on plan decisions than did the state assessments in *Travelers*.

regulation "relates to" the various subject matters to which it applies—medical care, legal services, day care for children, etc.; it does not relate to ERISA plans *as such*, or address the subject matter (the furnishing of employee benefits) that sets ERISA plans apart from other entities. In that critical sense, such regulation affects "employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' [ERISA] plans." *Shaw*, 463 U.S. at 100 n.21. See also *Greater Washington Bd. of Trade*, 506 U.S. at 130 n.1 (laws of "general applicability" frequently not preempted).[16]

The fact that state regulation in this category may have effects—even substantial effects—on ERISA plans does not alter the analysis. That principle was established by this Court's decision in *Travelers*. The Court in *Travelers* held that ERISA did not preempt New York statutes setting surcharges on hospital costs depending on whether they were paid for by a Blue Cross/Blue Shield plan, a commercial insurer, or an HMO.[17] The surcharges

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[16] There was no need for Congress to "save" such traditional areas from preemption as it did expressly for insurance, banking, and securities laws. Traditional state regulation and taxation of social welfare activities or the professions does not "relate to" plans insofar as ERISA does not itself provide law on those subjects; insurance, banking and securities laws, in contrast, are "saved" even if they do "relate to" plans. *Metropolitan Life*, 471 U.S. at 741-742.

[17] The Court remanded for consideration of whether the 13% surcharge on "self-insured funds" was preempted. *Travelers*, 115 S. Ct. at 1675 n.4. The United States stated in its amicus curiae brief at the petition stage in *Travelers* that "[a]pplication of the 13% surcharge to 'self-insured funds' *may* raise some distinct issues," not that it "*would* present entirely distinct issues," as respondents assert (Br. in Opp. 6 n.4; emphasis added). See Brief for the United States as Amicus Curiae at 14 n.5 in Nos. 93-1408, 93-1404, and 93-1415 (filed Sept. 14, 1994). The distinct issue we had in mind—but which was not before the Court—was whether the 13% surcharge payable by "self-insured funds" (but

have an impact on plans because they affect "the relative costs of competing insurance to provide [benefits]" and because they "bear[] on the costs of benefits"—like any regulation of "[q]uality standards" or "employment conditions"—by driving up the costs of the benefits. 115 S. Ct. at 1679. Yet the Court held that neither the effect on plan choice nor the modest overall draw on plan assets caused by the surcharges sufficed for preemption, because the New York scheme "leaves plan administrators right where they would be in any case, with the responsibility to choose the best overall coverage for the money." 115 S. Ct. at 1680. Such a scheme does not implicate "[t]he basic thrust of the pre-emption clause," 115 S. Ct. at 1677-1678, because it does not "preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one," 115 S. Ct. at 1679. Therefore, it does not "relate to" ERISA plans within the meaning of Section 514(a).[18] See also *Mackey*, 486 U.S. at

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not other favored payors like Blue Cross/Blue Shield) necessarily singled out self-insured plans for special treatment and thus "relate[d] to plans" for that reason. Here, no distinct analysis is necessary because the tax applies generally to hospitals and is entirely neutral with respect to ERISA plans.

[18] This Court in *Travelers* left open the question whether ERISA would preempt a state regulation that produced such an "acute" economic effect "as to force" an ERISA plan "to adopt a certain scheme of substantive coverage or effectively restrict its choice" of benefits or the manner in which they will be provided. *Travelers*, 115 S. Ct. at 1683. That question likewise need not be answered here, because the 0.6% HFA is not such "an exorbitant tax" or "so prohibitive" in its effect that it compels the Fund to cease providing hospitalization coverage, reduce the level of that coverage, or provide the coverage through other than Fund-owned facilities. *Id.* at 1681. Indeed, the HFA has even *less* effect on ERISA plans than the 9%, 11%, and 13% surcharges in *Travelers* because the HFA's uniform, low rate is not

830-841 (generally applicable state garnishment law held applicable to ERISA plans and not preempted under Section 514(a)).

We acknowledge that drawing the line between forbidden state regulation of what benefits an employer must provide and permitted state regulation of an area of commerce or activity in which a plan chooses to operate may not always be easy. But the broad outline of the distinction between a State's requirement that a plan provide certain benefits, as in *Metropolitan Life* or *Shaw*, and a State's requirement that plans abide by state regulations applicable to others similarly situated in the State, as in *Travelers* or *Mackey*, is clear. Although employer and employee must be left free to decide what package of hospitalization, day care, or legal services will best satisfy their needs, ERISA does not provide them with a means of opting out of generally applicable state laws regulating those areas simply by choosing to include them in an ERISA plan.

B. The HFA Is Not Preempted Under The Foregoing Principles Governing The Application Of Section 514(a) Of ERISA

1. Under the above analysis, the New York tax, as applied in this case, does not "relate to" an ERISA plan within the meaning of Section 514(a) of ERISA. First, the HFA has no effect on any of the fields in which ERISA itself provides governing law. When it enacted ERISA, Congress included no provisions concerning the regulation or taxation of hospitals, and New York's HFA tax does not affect any of the areas—such as reporting, disclosure, fiduciary responsibility, or civil enforcement—in

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designed to and will not have any effect on plans regarding what kind of health care to provide or how to provide it.

which ERISA set forth standards to govern employee benefit plans.

Second, the HFA does not itself refer to ERISA plans. To the contrary, the HFA statute is a law of general application because it applies to all "hospitals" without regard to their ownership, their patient composition, or the ultimate source of patient revenues subject to the tax. Cf. *United Wire, Metal & Machine Health & Welfare Fund* v. *Morristown Memorial Hosp.*, 995 F.2d 1179, 1192 n.6 (3d Cir.), cert. denied, 510 U.S. 944 (1993). The HFA operates in an area of traditional state regulation and "makes no reference to, [and] indeed functions irrespective of, the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139.[19]

Third, the HFA does not require (or forbid) employers or plans to provide any particular level of medical benefits to plan participants or beneficiaries. The HFA does not require the Fund to "provide a certain kind of benefit to cover a specified illness or procedure," *Metropolitan Life*, 471 U.S. at 728, or mandate that the Fund cover specified categories of persons defined by age or condition, *id.* at 729, such as infants, the elderly, or the disabled. Employers and ERISA plans in New York, as in other States, remain free to provide as much or as little hospital care as they desire.

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[19] If the HFA *did* expressly exempt plan-owned hospitals from the tax, which is the result respondents seek to achieve in this litigation, the exemption would be preempted as a law that refers to an ERISA plan and thereby "singles out ERISA employee welfare benefit plans for different treatment." See *Mackey* v. *Lanier Collection Agency & Servs., Inc.*, 486 U.S. 825, 830, 838 n.12 (1988). It would be an odd rule of preemption that required a court to carve out an exemption from a state law of general applicability in such circumstances, yet prohibited a State from including the very same exemption in its own law in the first place out of respect for the very same principles of preemption.

The HFA tax therefore does not fall within any of the three categories in which this Court has previously found ERISA preemption. The tax does, however, fall squarely within the fourth category described above: situations in which an employer or ERISA plan chooses to provide benefits by engaging in an activity subject to traditional state regulation of general application. It is therefore subject to that regulation. Respondents could have provided hospitalization benefits to plan participants either by purchasing hospitalization insurance, by reimbursing participants from plan funds for hospitalization expenses, or by negotiating directly with HMOs or local hospitals to provide hospitalization for plan participants. They chose none of those options, but instead decided to operate a hospital themselves. Nothing in ERISA suggests that by making that choice, respondents were also able to immunize themselves from all of the mechanisms—including generally applicable taxes—of state hospital regulation.[20]

Significantly, moreover, the HFA operates in the same realm as the surcharges upheld in *Travelers*, the regulation of health care. The Court observed in *Travelers* that "general health care regulation * * * historically has been a matter of local concern," and the Court concluded that "nothing in the language of [ERISA] or the context of

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[20] In *California Division of Labor Standards Enforcement* v. *Dillingham Construction, N.A.*, No. 95-789 (argued Nov. 5, 1996), we argued that the same rule was applicable in that case. The state regulation concerning apprenticeship training at issue there did not refer to ERISA plans because not all apprenticeship training is conducted through ERISA plans. See 95-789 U.S. Br. 12-13 (discussing *Massachusetts* v. *Morash*, 490 U.S. 107 (1989)). Therefore the regulation was a generally applicable law that an employer could not simply disregard because the employer in that case happened to choose to provide apprenticeship training through an ERISA plan. (We have provided copies of our brief in *Dillingham* to the parties in this case.)

its passage indicates that Congress chose to displace" such regulation. 115 S. Ct. at 1680.[21] In both *Travelers* and in this case, the state law has an effect on ERISA plans only because, and to the extent that, plans have chosen to engage in activity that is covered by the generally applicable state law. That incidental effect is too "tenuous, remote, or peripheral" to warrant a finding that the law 'relates to' ERISA plans. *Travelers*, 115 S. Ct. at 1680; *Shaw*, 463 U.S. at 100 n.21.

3. In its decision in this case on remand from this Court, the Second Circuit relied on a single factor to justify its adherence to its prior view that the HFA was preempted. Holding that "a state law's direct economic impact on ERISA plans is sufficient for a finding of preemption," Pet. App. 4a, the court below decided the case on the ground that the HFA constitutes a direct imposition because "there is no third party between the plan and the [HFA] tax," Pet. App. 3a. The court erred in holding that the single factor of direct economic impact on ERISA plans is a sufficient basis to warrant preemption.

The text of ERISA's preemption provision establishes that state laws that relate to ERISA plans "directly or indirectly," are superseded, see 29 U.S.C. 1144(c)(2), and this Court has not suggested that the "direct" or "indirect" nature of a state law's effect on ERISA plans is dispositive of whether the law relates to plans.[22] See *e.g.*,

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[21] In its original opinion in this case, the court of appeals reasoned that "the HFA targets only the health care industry," and "[b]ecause this industry is, by definition, the realm where ERISA welfare plans must operate," the HFA relates to plans and is preempted. Pet. App. 12a. *Travelers* established that that reasoning is mistaken.

[22] Respondents mischaracterize (Br. in Opp. to Pet. 6 n.4) the United States' position in *Travelers*. In urging that the indirect economic effects of the New York surcharges were insufficient for ERISA preemption, we expressed the broader view that "[a] state regulation does not relate to plans so long as its only effect is to subject all buyers in a broad-based market in which ERISA plans and others substantially participate to a single set of marketplace incentives." Brief for the United States as Amicus Curiae Supporting Petitioners at 9 in Nos. 93-1408, 93-1414 and 93-1415 (filed Nov. 15, 1994). The United States never contended, as respondents here have suggested, that the preemption analysis turns solely on the indirect or direct nature of the regulatory impact.

Travelers, 115 S. Ct. at 1678-1681. The Court in *Travelers* did refer to New York's surcharge statutes in terms of their "indirect economic influence" on plan choices. 115 S. Ct. at 1679. But that was because the only question before the Court in *Travelers* was whether the surcharges—which were not directly paid by plans—were preempted. Indeed, this Court has recognized that laws whose "effect is only indirect" may also relate to plans and be preempted. *Ingersoll-Rand*, 498 U.S. at 139; accord *Alessi*, 451 U.S. at 525; see *Travelers*, 115 S. Ct. at 1683. By the same token, this Court has held that ERISA does not preempt a generally applicable state garnishment law even as it applies to "participants' benefits in the hands of an ERISA welfare benefit plan." *Travelers*, 115 S. Ct. at 1680 (describing *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, *supra*); see *Mackey*, 486 U.S. at 841 ("ERISA does not forbid garnishment of an ERISA welfare benefit plan, even where the purpose is to collect judgments against plan participants"). The court of appeals was therefore wrong to conclude that the HFA "relates to" plans, within the meaning of Section 514(a) of ERISA, because it "imposes 'an immediate tax on payments and contributions which were intended to pay for participants' medical benefits.'" Pet. App. 4a (quoting its original decision).

If the Second Circuit were correct that "direct economic impact" is sufficient to warrant preemption, virtually every state law that taxes or regulates hospital care

would be invalidated insofar as it applies to hospitals owned by ERISA-covered plans. For example, payment of generally applicable unemployment compensation taxes, payroll taxes or real property taxes by a plan-owned hospital depletes plan assets at least as "directly" as payment of the provider tax here. See *Boyle* v. *Anderson*, 68 F.3d 1093, 1106-1107 (8th Cir. 1995), cert. denied, 116 S. Ct. 1266 (1996); *Morgan Guar. Trust Co.* v. *Tax Appeals Tribunal*, 587 N.Y.S.2d 252 (N.Y. 1992) (ERISA preempts state tax on gain from property transfer when applied to transfer of plan-owned property). Similarly, state laws that impose quality control or workplace standards on hospitals have an impact on plans that own hospitals that is fully as "direct" as the impact of the provider tax. In both situations, the law's effect necessarily falls on the plan because the plan provides hospital care rather than purchasing it from third-party providers in the marketplace. Indeed, if "directness" of a law's impact were the test of ERISA preemption, New York State's basic licensing laws could not survive in this setting, because they require "hospitals" to conform to state-approved systems of cost analysis, reporting and audits, and to maintain "premises, equipment, personnel, rules and by-laws, standards of medical care, and hospital service" that are "fit and adequate" according to state law.[23] N.Y. Pub. Health Law § 2805(1) and (2)(b) (McKinney 1993).

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[23] The breadth of the Second Circuit's decision is demonstrated by the court's decision to hold the HFA preempted as to *all* receipts for patient care by the Fund's centers—even when the Fund is merely acting like any other hospital in providing services to patients that are *not* paid for out of Fund assets. Thus, under the Second Circuit's decision, even when the Fund's hospitals treat patients who are not beneficiaries of the Fund (such as members of the PPGU) or whose care is paid for by workers' compensation, the income from those activities is immune from the HFA.

More broadly still, the court of appeals' reasoning leads to the conclusion that ERISA plans are exempt from a host of state laws that may tax or regulate the provision of other benefits and services that ERISA welfare plans provide in kind rather than purchase from third parties. In addition to hospital and medical services, welfare benefits may include death benefits, day care services and prepaid legal services. 29 U.S.C. 1002(1); see 29 U.S.C. 186(c). Application of the court of appeals' "direct effect" test would invalidate, as applied to plan-owned service providers, state laws that tax client funds escrowed with attorneys, staffing requirements for day care centers, and embalming procedures for funeral homes. It would also invalidate ethical requirements and malpractice laws insofar as such providers are concerned. In short, the court of appeals' reasoning would lead to preemption of myriad state laws that constitute an otherwise valid exercise of a state's traditional police powers, a result that "would effectively read the limiting language in § 514(a) out of the statute." *Travelers*, 115 S. Ct. at 1679. Moreover, federal preemption would leave a void in these areas historically regulated by States, and possibly serve as an invitation to unscrupulous operators to set up ERISA plans to avoid state regulation in those fields.[24]

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[24] Ironically, although the result would be to tend to decrease plan costs, it would not eliminate the impact of the preempted state laws. To the contrary, those laws would still have a dramatic impact on plan choice; if ERISA plans were the only entities in the State entitled to provide hospital services, legal services, day care, and the like, without paying state taxes or obeying state regulations, the resulting economic impact would surely drive many ERISA plans to provide such services themselves rather than contracting with others to provide them.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

WALTER DELLINGER
Acting Solicitor General

J. DAVITT MCATEER
Acting Solicitor of Labor

EWIN S. KNEEDLER
Deputy Solicitor General

ALLEN H. FELDMAN
Associate Solicitor

JAMES A. FELDMAN
Assistant to the Solicitor General

NATHANIEL I. SPILLER
Deputy Associate Solicitor

JUDITH D. HEIMLICH
Attorney
Department of Labor

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Supreme Court of the United States
OCTOBER TERM, 1996

BARBARA A. DE BUONO, NEW YORK STATE COMMISSIONER OF HEALTH, *et al.*,
Petitioners,
v.
NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, ETC., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE AMERICAN FEDERATION OF STATE COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

ANDREW D. ROTH
BREDHOFF & KAISER, P.L.L.C.
1000 Connecticut Ave., N.W.
Washington, D.C. 20036

NANCY E. HOFFMAN
CIVIL SERVICE EMPLOYEES' ASSOCIATION
143 Washington Avenue
Albany, New York 12210

LARRY WEINBERG *
JOHN C. DEMPSEY
AMERICAN FEDERATION OF STATE COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO
1101 17th Street, N.W.
Washington, D.C. 20036
(202) 775-5900

RICHARD J. FERRERI
DISTRICT COUNCIL 37
125 Barclay Street, Room 510
New York, New York 10007

* Counsel of Record

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

No. 95-1594

BARBARA A. DE BUONO, NEW YORK STATE COMMISSIONER OF HEALTH, *et al.*,
Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, ETC., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE AMERICAN FEDERATION OF STATE COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

This brief *amicus curiae* of the American Federation of State County and Municipal Employees, AFL-CIO ("AFSCME") is filed with the written consent of the parties, as provided for in the Rules of this Court.

INTEREST OF THE *AMICUS CURIAE*

AFSCME is a nationwide labor organization with a current membership of approximately 1.3 million public employees. Several thousand AFSCME members are employed by public hospitals in the State of New York and thus are affected by, and have an interest in, the issue of

whether a gross receipts tax on all hospitals operating within the State of New York is preempted by ERISA to the extent that the tax applies to the income of a private hospital owned and operated by an ERISA plan.

AFSCME's brief is joined by two AFSCME affiliates: New York City District Council 37 AFSCME, AFL-CIO ("District Council 37"); and State of New York, Civil Service Employees' Association, Local 1000, AFSCME, AFL-CIO ("CSEA"). District Council 37 represents New York City hospital employees, and CSEA represents New York State hospital employees.

SUMMARY OF ARGUMENT

In the real world of affairs ERISA welfare benefit plans engage in a variety of commonplace economic activities, consummate a variety of commonplace economic transactions, and forge a variety of commonplace economic relationships—all in the same form and in the same manner as non-ERISA plan entities. This range of activities, transactions and relationships has historically been, and currently is, subject to a myriad of state tax laws and regulatory laws that operate in areas of local concern not regulated by ERISA itself, and that apply without regard to the ERISA plan status of one of the involved parties.

It is our submission that this Court's prior decisions in *New York Conference of Blue Cross v. Travelers Ins.*, 115 S.Ct. 1671 (1995) and *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), establish the rule that ERISA § 514(a) does *not* preempt such state police power laws that (1) go to the economic activities, transactions, and relationships of both ERISA plans and non-ERISA plan entities that are not regulated by ERISA itself; and (2) do not in terms, or in practical effect, as a matter of economics or otherwise, mandate ERISA plan "employee benefit structures or their administration," or

provide "alternate enforcement mechanisms" to those provided by ERISA, *Travelers*, 115 S.Ct. at 1678. *See infra* pp. 3-13.

That non-preemption rule fully disposes of respondents' ERISA preemption challenge to New York's 0.6% gross receipts tax on all hospitals operating within the State. Simply stated, respondents cannot and do not contend that this generally-applicable state tax operates in an area regulated by ERISA itself, mandates changes in ERISA plan "benefit structures or their administration" or provides "alternate enforcement mechanisms" to those provided by ERISA.

And, neither of the grounds that respondents do rely upon for avoiding the application of that non-preemption rule to New York's gross receipts tax on hospitals—(1) that the tax detrimentally affects the "mission and purpose" of respondents' plan; and (2) affects the plan "directly" rather than "indirectly"—can withstand analysis. As we show, neither provides a principled basis for distinguishing the State laws upheld against ERISA preemption challenges in *Travelers* and *Mackey*. *See infra* pp. 13-22.

ARGUMENT

I.

A. The Employee Retirement Income and Security Act defines an "employee welfare benefit plan" to include "any plan, fund or program . . . for the purpose of providing for its participants or their beneficiaries . . . [*inter alia*] medical, surgical or hospital care or benefits . . . ." ERISA § 3(1)(B), 29 U.S.C. § 1002(1)(B). And, with respect to such plans, ERISA regulates the reporting and disclosure of plan benefits and the fiduciary responsibilities of those who manage and control the plan.

ERISA, then, covers the establishment of a legal structure (1) for defining a set of medical, surgical or hospital

care benefits and a set of beneficiaries; and (2) for capitalizing, and for then defraying, the cost of providing those benefits; but ERISA does *not* cover the actual provision of the medical, surgical or hospital care to the beneficiaries. *See Fort Halifax v. Coyne*, 482 U.S. 1, 7-19 (1987) (distinguishing ERISA "welfare benefit plans" and ERISA "benefits"). ERISA provides, too, that "the provisions of this subchapter shall supersede . . . State laws insofar as they may . . . relate to any employee benefit plan . . ." ERISA § 514(a), 29 U.S.C. § 1144(a).

Respondents in this case maintain that an employee welfare benefit plan that chooses to provide medical, surgical or hospital care services through plan owned and operated facilities rather than to provide monetary benefits that defray the cost of the services of third-party health care providers are shielded by ERISA from State tax (and regulatory) laws that otherwise govern health care providers and facilities.

The meaning of the phrase "relate to" in ERISA's preemption provision has proved elusive, and that is to put the difficulty of this ongoing inquiry in the mildest of terms. Even with the benefit of twenty years of litigating elucidation we make no pretense of having reached the point of being able to provide to the Court for its consideration a template that guides § 514(a) decisionmaking. But we do submit that there is at least one discrete *non*-preemption rule that can now be stated with confidence and that this rule governs this case.

In the real world of affairs ERISA welfare benefit plans engage in a variety of commonplace economic activities, consummate a variety of commonplace economic transactions, and forge a variety of commonplace economic relationships—all in the same form and in the same manner as non-ERISA plan entities. Plans hire and employ personnel and purchase and rent office, and other, properties. Plans also purchase all manner of goods for the

plan's use and a variety of services—including hospital care—from third parties on the market for and on behalf of the plan or its beneficiaries. And, as here, plans provide services to beneficiaries—including hospital care—through plan owned and operated facilities.

This range of activities, transactions and relationships has historically been, and currently is, subject to a myriad of State tax laws and regulatory laws raising revenue, addressing market imperfections or safeguarding the public health and safety that apply without regard to the ERISA plan status of one of the involved parties. These laws govern, *inter alia*, the hiring and retention of employees, the buying and selling of services and goods, the standards for operating hospital facilities, etc. Such State laws—which in this country form the core of the legal structure within which the provision of services and goods take place supplemented by narrow bands of interstitial federal legislation—are paradigm examples of the States' historic police power. And, such laws address concerns far outside the realm of concerns addressed by ERISA.

All this being so, it is our submission that ERISA does *not* preempt such State police power laws that (1) go to economic activities, transactions and relationships of both ERISA plans and non-ERISA plan entities that are not regulated in ERISA itself; and (2) do not in terms, or in practical effect, as a matter of economics or otherwise, mandate ERISA plan "employee benefit structures or their administration" or provide "alternate enforcement mechanisms" to those provided by ERISA, *New York Conference of Blue Cross v. Travelers Inc.*, 115 S.Ct. 1671, 1677 (1995).

On that submission, as we show, the New York statute here imposing a 0.6% gross receipts tax on all private hospitals operating within the State—including hospitals owned and operated by an ERISA plan and those owned and operated by non-ERISA plan entities—is *not* preempted by ERISA in any respect.

Because this case is related so closely to *Travelers*—and because our submission as to the governing rule is drawn largely from *Travelers* and what we believe are its fair implications—we begin by outlining *Travelers*' rationale. With *Travelers*' lessons in mind we then consider the variation on the *Travelers*' theme presented in this case.

B. (1) *Travelers* concerned "[a] New York statute requir[ing] hospitals to collect surcharges from patients covered by a commercial insurer but not from patients insured by a Blue Cross/Blue Shield plan, and . . . subject[ing] certain health maintenance organizations (HMOs) to surcharges that vary with the number of Medicaid recipients each enrolls." 115 S.Ct. at 1673. The Court—after canvassing the general principles on preemption and its ERISA § 514(a) jurisprudence to that juncture—stated:

> We hold that the provisions for surcharges do not "relate to" employee benefit plans within the meaning of ERISA's pre-emption provision, § 514(a), 29 U.S.C. § 1144(a), and accordingly suffer no pre-emption. [115 S.Ct. at 1674.]

(2) The proper starting points for analysis, said the *Travelers* Court, are these: *First*,

> in cases like this one, where federal law is said to bar state action in fields of traditional state regulation, we have worked on the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." [115 S.Ct. at 1676 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)) (citation omitted).]

Second, "uncritical literalism is no . . . help" in construing § 514(a)'s "clearly expansive" language because "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, uni-

versally, relations stop nowhere'." 115 S.Ct. at 1677 (quoting H. James, Roderick Hudson xli (New York ed., World's Classics 1980)). "But that, of course, would be to read Congress's words of limitations as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality." *Id.*

Third, the Court's "prior attempt [in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983)] to construe the phrase 'relate to' does not give us much help drawing the line here." 115 S. Ct. at 1677. Thus,

> [w]e simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive. [*Id.*]

And, *fourth*,

> [w]e have found that in passing § 514(a), Congress intended
>
> > "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand* [*v. McClendon*], 498 U.S. [133], 142 [1990].
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> [That being so the Court has held] ERISA pre-empted[,] state laws that mandated employee benefit structures or their administration. Elsewhere, we have held that state laws providing alternate enforce-

ment mechanisms also relate to ERISA plans, triggering pre-emption. [115 S.Ct. at 1677-78.][1]

(3) Against that background, the *Travelers* Court turned to the New York hospital surcharge law there at issue—a law whose "purpose and effect," the Court concluded, "distinguish[ed]" it from the State laws that had been held ERISA preempted. 115 S. Ct. at 1678.

The distinctions the Court emphasized are, first, that hospital charge differentials by type of insurer and by region have always existed in regimes in which there is no State regulation of such charges as well as those regimes in which there is such regulation; and, second, that such charge differentials "do[] not bind plan administrators to any particular choice" and in that sense do not "function as a regulation of an ERISA plan itself." 115 S.Ct. at 1679. Given the "common character of [such] rate differentials even in the absence of state action," said the *Travelers* Court, "it is unlikely that ERISA pre-emption was meant to bar [state laws that generate] such indirect economic influences" on ERISA plan decisionmaking. *Id.*

Then, of particular pertinence here, the *Travelers* Court added:

> [T]he existence of other common state action with indirect economic effects on a plan's costs leaves the intent to pre-empt even less likely. Quality standards, for example, set by the State in one subject area of hospital services but not another would affect the relative cost of providing those services over others and, so, of providing different packages of health insurance benefits. Even basic regulation of employment conditions will invariably affect the cost and price of services. . . . [S]uch state regulation will indirectly affect what an ERISA or other plan can afford or get for its money. [115 S.Ct. at 1679.]

[1] In addition to *Shaw* and *Ingersoll-Rand*, the Court listed *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) as falling within this class of cases finding ERISA preemption. The State laws at issue in *Alessi*, *Shaw* and *FMC Corp.* dictated the structure of ERISA benefit plans; in *Ingersoll-Rand*, the State law concerned the protection and enforcement of an express ERISA right.

And, the Court drew the following lesson from its reasoning:

> [I]n the absence of a more exact guide to intended preemption than § 514, it is fair to conclude that mandates for rate differentials would not be preempted unless other regulation with indirect effects on plan costs would be superseded as well. The bigger the package of regulation with indirect effects that would fall on the respondent's reading of § 514, the less likely it is that federal regulation of benefit plans was intended to eliminate state regulation of health care costs.
>
> Indeed, to read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services, would effectively read the limiting language in § 514(a) out of the statute. . . . [*N*]*othing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.* . . . . [115 S.Ct. at 1679-80]

Consistent with the above-described rationale, the *Travelers* Court tempered its holding in only one regard:

> We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under § 514. [115 S.Ct. at 1683.]

(4) The *Travelers* Court also stated that its holding is "confirmed by our decision in *Mackey v. Lanier Collection*

Agency & Service, Inc., 486 U.S. 825 (1988), which held that ERISA preemption falls short of barring application of a general state garnishment statute to participants' benefits in the hands of an ERISA welfare benefit pl[illegible]." 115 S.Ct. at 1680. *Travelers* explains that in *Mackey*

> [w]e took no issue with the argument of the *Mackey* plan's trustees that garnishment would impose administrative costs and burdens upon benefit plans, *id.*, at 831, but concluded from the text and structure of ERISA's pre-emption and enforcement provisions that "Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans, even when those mechanisms prevent plan participants from receiving their benefits." *Id.*, at 831-832. [115 S.Ct. at 1680.]

And, as the *Mackey* Court itself had made clear, garnishment actions against ERISA plans stand on no different footing in this regard than the wide array of state law claims that might be brought against ERISA plans and non-ERISA plans alike:

> [L]awsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan . . . are relatively commonplace. Petitioners and the United States (appearing here as *amicus curiae*) concede that these suits, although obviously affecting and involving ERISA plans and their trustees, are not pre-empted by ERISA § 514(a). [486 U.S. at 833.]

C. The basic point of the ERISA preemption provision, then, is "to ensure that [ERISA] plans and plan sponsors would be subject to a uniform body of *benefits* law." *Ingersoll-Rand*, 498 U.S. at 142 (emphasis added). That entails the conclusion that State laws that "mandate employee benefit structures or their administration" by, for example, "imposing substantive coverage requirements

binding plan administrators," as well as State laws that "provide alternate enforcement mechanisms" for an ERISA norm, *do* "relate to" ERISA plans within the meaning of § 514(a). *See Travelers*, 115 S.Ct. at 1677-78 (discussing the overall preemption rule) and *id.* at 1680-81 (discussing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985)). Those conclusions fill in the central features of § 514(a)'s "clearly expansive" area of preemption.

At the same time, Congress, the Court has concluded, did not press this uniformity interest to the point where it works wholesale repeal of State police power laws that apply both to ERISA plan transactions, activities and relationships and to non-ERISA plans entity transactions, activities and relationships of the same kind.

Rather, where such state laws apply to entities with which ERISA plans have economic relations—such as hospitals that provide ERISA plan beneficiaries hospital care at the plan's expense—and apply on the same terms whether the hospital is caring for an ERISA plan beneficiary or a non-ERISA plan beneficiary, ordinarily the law is *not* preempted by reason of its effects on the plan or on plan costs.

Congress, in other words, did *not* contemplate that ERISA plans are entitled to the uniform police power regulation of the third-person providers of the services—*e.g.*, hospital care—the plan is, in the final analysis, established to provide. Indeed, given the fact that ERISA does not, for example, regulate hospital accreditation, any aspect of hospital staffing or operations, or the costing and pricing of hospital services, and the further fact that the laws regulating such matters have a large and certain effect on ERISA plans established to finance the provision of hospital care, any other conclusion, as the *Travelers* Court emphasized, would create a huge—and unprecedented—legal no-man's land in a critical area of traditional State concern.

Travelers involved a State law regulating certain charges by third-person hospitals to insurers and HMOs that passed those changes on to ERISA plans and to others. And, *Travelers'* holding is calibrated to ERISA § 514(a)'s effect on State laws having such an indirect economic impact on ERISA plans and on their decisions as to what benefits to provide and how to provide those benefits. But *Travelers' ratio decidendi*, we believe, rests on a far more fundamental point of far greater consequence.

Travelers holds the New York hospital surcharge law there *not* preempted *not* because of its unique characteristics and *not* because the State regulated hospitals were third-person providers to ERISA plans (rather than ERISA plans or entities owned by ERISA plans) but on the following general principle: the New York surcharge law is part and parcel of the State's general regulation of health care, the law has only a consequential—and in that sense "indirect"—economic impact on ERISA plan "employee benefit structures and their administration" *and* "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." 115 S.Ct. at 1680.

Given *Travelers'* rationale, it follows that State police power laws are not preempted merely because the law imposes "administrative costs and burdens upon benefit plans" on the same, non-discriminatory basis as the law imposes such costs and burdens on non-ERISA plan entities. *Mackey*—and *Travelers'* elaboration of *Mackey*—stand for just this unsurprising proposition. For nothing in reason, and nothing in ERISA, suggests—much less compels—the conclusion that an ERISA plan's decision to implement its benefit program, in whole or in any part, through its own service facility is to generate a different line of demarcation between the area of federal legal uniformity and the area of State legal diversity, than the decision to implement a benefit program by using the plan's corpus to pay a third person to provide the same service to the plan or to plan beneficiaries. The contrary conclu-

sion exalts organizational form—and the plan decision whether to "insource" or "outsource"—above legal substance. That could not be plainer here where the ERISA plan hospitals exempted by the court below from the New York gross receipts tax are "incorporated separately as New York not-for-profit corporations and are licensed by the New York State Department of Health as disagnostic and treatment centers." Petition for a Writ of Certiorari, 4.

Indeed, to suppose that Congress intended in enacting ERISA to preclude the States from requiring ERISA plans that choose to engage in activities traditionally taxed and regulated by the States to pay the same taxes and comply with the same police power regulations that all other entities involved in that same activity must pay and comply with is to suppose that Congress created an ERISA-centric world—a world in which all ERISA plans operate in an hermatically-sealed environment insulated from all State influence. It is to suppose, in other words, that Congress intended to place ERISA plans above all the civil laws of the States in which the plan operates by *exempting* the plan from the State's laws.

It is very much to the point that so far as we are aware, there is no context in which Congress has ever expressed the intent to take such an extraordinary step with respect to any private entity. It is even more to the point that precisely because this is so—and precisely because of the presumption against the preemption of the States' historic police power—that *Travelers* and *Mackey* squarely reject the proposition that Congress took such a step with respect to ERISA plans in ERISA § 514(a).

II.

With *Travelers* and its lessons in mind, we now turn to consider the status of the specific state statute at issue in this case—New York's 0.6% gross receipts tax on all hospitals operating within the State—under ERISA § 514(a).

A. It facilitates analysis of the New York tax to begin with a situation that is at one remove from the situation here and that we submit is governed by *Travelers* in terms. The great majority of ERISA welfare benefit plans purchase hospital care for their beneficiaries from third-party hospitals and do not provide that care to their beneficiaries through hospitals that the ERISA plan itself owns and operates. Such ERISA plans are burdened by New York's gross receipts tax on hospitals in precisely the same limited manner as ERISA plans were burdened by the surcharge law upheld in *Travelers*: in both settings, the plans experience an increase in the cost of providing health benefits to their beneficiaries over that cost if the State had not pased the tax law or the surcharge law (or taken other legislative/administrative action that increases the costs the hospital builds into its charges or that sets hospital charges).

Travelers' holding that the New York surcharge law is *not* ERISA preempted therefore compels the conclusion that the gross receipts tax is *not* preempted insofar as it applies to ERISA welfare benefit plans that purchase hospital services for their beneficiaries from third-person hospital care providers.

B. Thus, the narrow open question presented by this case is whether there is a different preemption result with respect to those ERISA plans that have made the decision to provide hospital care to their beneficiaries through medical centers that the plans themselves own and operate. The court below answered this question in the affirmative, and respondents seek the same answer from this Court both on the ground relied upon by the court below and on an independent ground as well. In the two subsections that follow, we address both grounds of decision urged by respondents, and demonstrates that both are wanting.

(1) In the court below, the State argued that under *Travelers* and *Mackey* a State may collect a variety of taxes of general application—including payroll taxes, sales

taxes, utility taxes and gasoline taxes—from ERISA plans that choose to own and operate hospitals within the State and that the 0.6% gross receipts tax on hospitals is no different in kind from those state taxes. *See* Appendix To Petition For A Writ Of Certiorari ("Pet. App.") 11a. Without questioning the State's premise that these various other State taxes of general application would under the reasoning of *Travelers* and *Mackey* survive a preemption challenge by ERISA plans that own and operate hospitals within the State, the court below found that the State's gross receipts tax on hospitals "is distinguishable from these laws of general application." *Id.* at 12a.

In its initial opinion, the court below stated this distinction as follows:

> The HFA does not apply broadly to every sector of society in New York; nor does it apply to the Fund simply because it engaged in certain kinds of activities which any other member of society might engage in. . . . Rather, the HFA targets only the health care industry . . . by definition, the realm where ERISA welfare plans must operate. . . . In a case such as the present one where the plan has chosen to provide medical benefits through self-run medical centers, the HFA operates as an immediate tax on payments and contributions which were intended to pay for participants' medical benefits. The HFA thus directly affects the Fund in its principal role as an employee welfare benefit plan. It does not touch the Fund only slightly on the outer limits of its plan activities. It affects the very operations and functions that make the Fund what it is, a provider of medical, surgical, and hospital care to its participants and their beneficiaries.
>
> We thus conclude that the HFA "relates to" the Fund and does so in a very direct way. The tax depletes those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for the benefits re-

> ceived. Both impacts will detrimentally affect the central mission and purpose of the Fund . . . . [Pet. App. 12a.]

And, in its post-*Travelers* opinion, the court below reiterated that the gross receipts tax

> depletes the Fund's assets directly, and thus has an immediate impact on the operations of an ERISA plan. As we observed in our original opinion, the HFA imposes "an immediate tax on payments and contributions which were intended to pay for participants' medical benefits . . . [and] thus directly affects the Fund in its principal role as an employee welfare benefit plan." [Pet. App. 3a-4a.]

In its Brief in Opposition, respondents invoked the foregoing as the short and definitive answer to "the wolf cry repeated in the petition to this Court," that a finding of preemption in this case would shield ERISA plans from the numerous other state taxes and regulations of general application that result in increases in the cost of providing health care benefits. *See* Respondents' Brief in Opposition at 17. As respondents see it, the court below was correct in recognizing that these various State taxes and regulations are of a substantially different nature than a gross receipts tax on hospitals because the latter—and only the latter—will "sap the lifeblood" of ERISA plans and "directly hinder their essential functions." *Id.* at 18.

With all respect to the court below, and to respondents, that reasoning cannot bear a moment's scrutiny. Where, as here, an ERISA plan has chosen to own and operate a hospital in lieu of purchasing hospital care from third-party providers, the plan, to accomplish its "mission and purpose" as the plan has defined it, *see* Pet. App. 12a, must like any other entity engaged in such a mission do all the following which is essential to the provision of hospital care—purchase or lease a building; hire and pay employees; and purchase equipment and supplies. In many States, the purchase or lease of a building will trigger the imposition of a property tax; the hiring and

payment of employees will trigger a payroll tax; and the purchase of equipment and supplies will trigger a sales tax. The payment of one or more of these state taxes by an ERISA plan that owns and operates a hospital will—*in just the same manner as the payment of an income or "gross receipts" tax on hospitals generally*—"deplete[ ] those assets earmarked for the provision of health care benefits" and thereby detrimentally affect the plan's ultimate "mission" by "caus[ing] the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received." Pet. App. 12a.

In short, *any* state tax of general application that falls upon an ERISA plan that has chosen to engage in activity subject to the tax will leave the plan financially worse off than the plan would be in the absence of the tax. There is no rational basis for distinguishing between various forms of state taxes in this respect.[2]

Equally to the point, although the court below did not treat with *non*-tax, police power regulations of general application that will invariably fall upon ERISA plans when they choose to operate in an area—the provision of hospital care—that profoundly affects the health and welfare of the community, it cannot be gainsaid that such *non*-tax regulations have an impact on the "mission and purpose" of an ERISA plan hospital, Pet. App. 12a, of the same kind as the various State taxes of general application discussed above. Accordingly, just as there is no logical basis for distinguishing between New York's gross receipts tax on hospitals and other State taxes of general application in terms of their impact on the "mission and purpose" of ERISA plans that have chosen to own and operate hospitals within the State, there is no logical basis for at-

[2] As we have already shown *supra* pp. 10-18, perhaps the most glaring deficiency in the reasoning of the court below is that it cannot be squared with the holding and logic of *Travelers* nor with *Travelers* evident application to a gross receipts tax imposed on third-party hospitals from whom ERISA welfare plans purchase hospital services.

tempting to draw such a distinction between New York's gross recepits tax on hospitals and the various *non*-tax State police power regulations that are applicable to the provision of hospital services generally.

New York's hospital licensing law, for example, requires all hospitals to conform to State-approved systems of cost-analysis, reporting and audits, and to maintain "premises, equipment, personnel, rules and by-laws, standards of medical care, and hospital service" that are "fit and adequate" according to State law. *See* N.Y. Pub. Health Law § 2805(1) and (2)(b) (McKinney 1993).

By their terms, these hospital licensing regulations force certain operational choices on an ERISA plan that has chosen to own and operate a hospital for its beneficiaries, thereby, in the words of the court below, "directly . . . affect[ing] the very operations and functions that make the Fund what it is." Pet. App. 12a.

Moreover, to the extent that these State-regulation-compelled choices require the ERISA plan hospital to make greater expenditures than it would otherwise make if left to its own devices in an unregulated environment, those expenditures will, in the words of the court below, "deplete[ ] those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received." *Id.* (Or, to use respondents' words, "sap the lifeblood" of the Fund).[8]

Nor is this all. The internal inconsistencies in the decision below become clearer yet as applied to ERISA plans that provide rather than purchase other types of welfare benefits and services, such as day care services. *See generally* 29 U.S.C. § 1002(1). The acquisition of any property, personnel and supplies that an ERISA plan might need to provide day care services to its beneficiaries would subject the plan to State taxes of general application such as property taxes, payroll taxes an sales taxes. And, day care is unquestionably the kind of activity affecting the health and well-being of the community that routinely is the subject of State police power regulation.

[8] The same analysis would apply to, for example, medical malpractice suits, which have a dual impact on all hospitals including those owned and operated by ERISA plans—from the standpoint of setting standards for the provision of medical services and from a pure cost standpoint.

The payment of these State taxes by ERISA plans engaged in the provision of day care services, and compliance by such ERISA plans with the run of State police power regulations applicable to the provision of day care services, would—for the reasons explained above in the context of hospital services—have a substantial impact on the "mission and purpose" of such ERISA plans in precisely the same manner as a generally-applicable income or gross receipts tax on day care services.

As an analytical matter, then, either *all* State taxes and regulations of the kind discussed above "relate to" ERISA plans within the meaning of ERISA § 514(a), or *none* of them do. It is no "wolf cry," *supra* p. 16, to point out that the rationale of the court below for finding New York's gross receipts tax on hospitals to be preempted by ERISA would, if accepted, sweep away State police power taxation and regulation of activities traditionally taxed and regulated by the States to the extent that ERISA plans have chosen to engage in those activities. That is why that rationale is directly contrary to *Travelers'* rationale.

(2) Here and in the court below, respondents have sought to distinguish the instant case from *Travelers* on the independent ground that in *Travelers* the economic impact on ERISA plans of the surcharges imposed by New York on commercial insurers and HMOs was merely "indirect," whereas here the economic impact of New York's gross receipts tax on ERISA plans that have chosen to own and operate hospitals is "direct."

As our discussion of *Travelers* and *Mackey* in Part I foreshadows, this distinction between "indirect" and "direct" economic effects on ERISA plans can no more carry the day for respondents than the distinction that the court below attempted to draw between State taxes of general application that do affect and do not affect the "mission and purpose" of ERISA plans. We add only a few words here.

To begin, the fact that New York's gross receipts tax on hospitals imposes a "direct" cost on ERISA plans that have chosen to own and operate hospitals—while offered by respondents as a basis for distinguishing the instant case from the *Travelers'* situation—is not offered, and cannot possibly serve, as a basis for distinguishing the instant case from the facts of the *Mackey* situation or from *Travelers'* elaboration of *Mackey*.

General state garnishment statutes of the kind considered in *Mackey* plainly impose *direct* costs on ERISA plans that are served with garnishment orders. *See Mackey*, 486 U.S. at 831. The same "obviously" is true with respect to "lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan." *Id.* at 833. The *Mackey* Court did *not* deem this kind of "direct" imposition of costs on ERISA plans to be a basis for holding the general State garnishment statute preempted by ERISA § 514(a); nor did the Court view this "direct" imposition of costs on ERISA plans as an obstacle to accepting the concession of the *Mackey* petitioners and the United States that ERISA § 514(a) does not immunize ERISA plans against a wide range of state law claims that might be brought against them—and, of necessity, does not immunize such plans from the force of such state laws and the costs of complying with those laws.

Indeed, it was on the basis of *Mackey* that the court below itself was forced to acknowledge that not all State taxes of general application that impose direct costs on

hospitals owned and operated by an ERISA plan are on that account preempted by ERISA § 514(a). *See* Pet. App. 11a-12a.

Nor does the theory that New York's gross receipts tax on hospitals falls "directly" rather than "indirectly" on ERISA plans that have chosen to own and operate their own hospitals supply a principled basis for distinguishing the instant case from *Travelers*.

The *Travelers* Court, after all, upheld New York's surcharges on commercial insurers and HMOs against an ERISA preemption challenge on the Court's express understanding that those surcharges would be passed on to those persons and entities, *including ERISA plans*, that chose to purchase commercial insurance or HMO membership. *See* 115 S.Ct. at 1678-79 ("Since the surcharges are presumably passed on at least in part to those who purchase commercial insurance or HMC membership, their effects follow from their purpose."). On that understanding ERISA plans would (along with others) bear the ultimate economic burden of the surcharges just as surely as the plans would bear the burden of a tax payable by a plan owned hospital.

That being so, the logic of *Travelers* indicates that the decision uses the terms "indirect" and "direct" in a different sense than respondents use those terms.[4] The *Travelers* Court's rationale for finding *no* ERISA preemption was that while the New York surcharge law obviously and substantially affected the relative cost and attractiveness of various insurance packages that ERISA plans might

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[4] It is worthy of note that *Alessi*, *Shaw* and *FMC Corp.* use the terms "direct" and "indirect" in yet a different sense—to characterize laws that are addressed to benefit issues in terms and laws that are addressed to a broader subject, such as workers compensation, and that have application to benefit issues. As *Alessi* makes clear, in that context the Court has refused to find any distinction of substance for ERISA § 514(a) purposes in the direct/indirect dichotomy.

purchase, the law did not run afoul of the "basic thrust of the [ERISA] pre-emption clause" by "*mandat*[*ing*]" the plan's "employee benefit structures and their administration." 115 S.Ct. at 1677-78 (emphasis added).

This rationale applies equally to State-mandated costs that fall equally on ERISA plans that provide hospital care through a plan owned and operated hospital and on third person providers of hospital care services. In both the State law has only an *indirect* effect on the plans' "employee benefit structures and their administration." And, under *Travelers*, such an effect does *not* trigger ERISA preemption.

CONCLUSION

For the foregoing reasons, the decision and judgment of the United States Court of Appeals for the Second Circuit in this case should be reversed.

Respectfully submitted,

ANDREW D. ROTH
BREDHOFF & KAISER, P.L.L.C.
1000 Connecticut Ave., N.W.
Washington, D.C. 20036

NANCY E. HOFFMAN
CIVIL SERVICE EMPLOYEES' ASSOCIATION
143 Washington Avenue
Albany, New York 12210

LARRY WEINBERG *
JOHN C. DEMPSEY
AMERICAN FEDERATION OF STATE COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO
1101 17th Street, N.W.
Washington, D.C. 20036
(202) 775-5900

RICHARD J. FERRERI
DISTRICT COUNCIL 37
125 Barclay Street, Room 510
New York, New York 10007

* Counsel of Record

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No. 95-1594

IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

BARBARA A. DE BUONO, MD., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

On Writ of Certiorari To The United States Court of Appeals For the Second Circuit

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BRIEF *AMICUS CURIAE* OF THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF PETITIONERS

JEFFREY LEWIS
SIGMAN, LEWIS & FEINBERG
405 Fourteenth St., Suite 1100
Oakland, CA 94612
(510) 839-6824

MARY ELLEN SIGNORILLE
(Counsel of Record)
601 E Street, N.W
Washington, DC 20049
(202) 434-2070

Counsel for *Amicus Curiae*
National Employment Lawyers Association

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No. 95-1594

IN THE
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OCTOBER TERM, 1995

BARBARA A. DE BUONO, MD., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

On Writ of Certiorari To The United States Court of Appeals For the Second Circuit

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BRIEF *AMICUS CURIAE* OF THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF PETITIONERS

STATEMENT OF INTEREST OF *AMICUS CURIAE*

The National Employment Lawyers Association (NELA) is a voluntary organization, founded in 1985, of approximately 3,000 attorneys who specialize in representing individuals in controversies arising out of the workplace. It is the country's only professional membership organization comprised of lawyers who represent employees in cases involving employment discrimination, employee

benefits, wrongful discharge, and other employment-related matters. NELA has devoted itself to supporting precedent-setting litigation affecting the rights of individuals in the workplace.

NELA is qualified to brief the Court on the implications of the decision in this case, having participated as *amicus curiae* in numerous cases involving ERISA and other employment laws, including among others, *Varity Corp. v. Howe*, 116 S. Ct. 1065 (1996), *John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86 (1993), and *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

NELA members' clients and other participants in pension and welfare plans depend on ERISA to protect their rights under private employer-sponsored employee benefit plans. 29 U.S.C. § 1001 *et seq*. Contrary to its original purpose of safeguarding employee benefits, ERISA through its preemptive effect has been used to deprive employees of rights they previously enjoyed under state law while failing to provide any comparable federal remedies. The proliferation of ERISA preemption cases raises the question of whether ERISA is having an effect contrary to that intended by those who favored its adoption. To achieve uniform administration of employee benefit plans, ERISA preemption need only be used as a shield, not as a sword.[1/]

This case, along with other ERISA preemption cases

[1/] *See Rokohl v. Texaco*, 77 F.3d 126, 130 (5th Cir. 1996) ("an employer may not use its ERISA plan as a 'gimmick' to trigger preemption and thereby avoid litigation in state court. In the classic metaphor, ERISA preemption may be used as a shield but not as a sword." (citations omitted)).

currently pending before the Court,[2/] presents the Court with the opportunity to establish a more workable framework for the lower courts to use for analyzing ERISA preemption cases. In particular, the lower courts need a more precise test for determining the boundaries of the phrase "relates to an employee benefit plan."

The decision in this case will have a direct and vital bearing on the economic security of NELA members' clients and other participants of pension and welfare plans. In light of the significance of the issues presented by this case, NELA respectfully submits this brief *amicus curiae*.[3/]

SUMMARY OF ARGUMENT

The number of cases the Court has decided construing the phrase "relates to an employee benefit plan" in ERISA's preemption clause illustrates the lower courts' struggle to define the limits of "relates to."[4/] As this Court has recognized, this clause is not a model of legislative drafting, and it has been difficult to provide clear guidance to the lower courts to demarcate the limits

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[2/] *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 57 F.3d 712 (9th Cir. 1995), *cert. granted*, 116 S. Ct. 1415 (U.S., Apr. 15, 1996) (No. 95-789) (whether ERISA preempts state prevailing wage laws); *Boggs v. Boggs*, 89 F.3d 1169 (5th Cir.), *cert. granted*, 65 USLW 3332 (U.S., Nov. 1, 1996) (No. 96-79) (whether ERISA preempts state community property laws).

[3/] The written consent of each party has been filed with the Clerk of the Court pursuant to Supreme Court Rule 37.3.

[4/] *E.g., New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *Mackey v. Lanier Collection Agency Service*, 486 U.S. 825 (1988); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724 (1985); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

of this clause.[3/] Hence, not only has development of a uniform framework to analyze ERISA preemption been frustrated, but the courts have been flooded with removed cases and preemption claims.

NELA suggests the following framework to use in analyzing ERISA preemption claims.[4/] First, where a state law directly conflicts with ERISA, the state law is preempted by ERISA. *See, e.g., District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). Second, if a claim can be brought under ERISA § 502(a), then the state law action must be preempted under ERISA § 514(a). *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Third, if the state law is not in direct conflict with ERISA or a claim cannot be brought under ERISA § 502(a), then it must be determined if that state law specifically refers to an ERISA plan; if so, it is preempted. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. ("Travelers")*, 115 S. Ct. 1671, 1677 (1995); *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 841 (1988). Fourth, if the state law does not directly reference an ERISA plan, it is presumed that a state

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3/ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers' Ins. Co.*, 115 S. Ct. 1671, 1676 (1995).

4/ ERISA preemption analysis involves numerous steps. The initial inquiries under ERISA § 514(a) are whether a State, state law and an employee benefit plan are involved. ERISA §§ 514(c)(1) & (c)(2), 29 U.S.C. §§ 1144(c)(1) & (c)(2). If any one of these inquiries is negative, there can be no preemption. *See Massachusetts v. Morash*, 490 U.S. 107 (1989) (vacation payments from an employer's general assets did not constitute a plan and therefore state law cannot be preempted); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (a state law requiring a one-time severance payment was not preempted because there was no plan due to a lack of an ongoing scheme or administrative structure). Here, none of the parties dispute that a State, state law and employee benefit plan are involved. Only after the existence of a plan and a state law are established does one begin NELA's analysis.

law in an area of traditional state regulation is not preempted, *Travelers*, 115 S. Ct. at 1671, unless the state law directly regulates an ERISA-governed relationship, *see, e.g, Airparts Company, Inc. v. Custom Benefit Services of Austin*, 28 F.3d 1062 (10th Cir. 1994); *General American Life Ins. Co. v. Castonguay*, 984 F.2d 1518 (9th Cir. 1993), or the state law accomplishes through an acute indirect economic effect what it cannot do directly, that is, regulate ERISA plans. *See Travelers*, 115 S. Ct. at 1683.

Adoption of such a framework will serve to produce more uniformity in the interpretation of the phrase "relates to an employee benefit plan," to implement Congress' intent in enacting ERISA's preemption clause, and to decrease the number of preemption cases and claims flowing into the federal courts.

Applying this framework to the facts of this case, the New York state law taxing gross receipts from patient care services and general operations of all hospitals in New York does not directly conflict with ERISA, does not duplicate an ERISA claim under ERISA § 502(a), does not reference an ERISA plan, and is a state law in an area of traditional state regulation that neither directly regulates an ERISA-governed relationship nor produces an acute indirect economic effect. Thus, the state law does not "relate to an employee benefit plan", and it is not preempted under ERISA §514(a), 29 U.S.C. § 1144(a).

ARGUMENT

I. THE COURT SHOULD DEVELOP A MORE WORKABLE FRAMEWORK FOR ANALYZING ERISA'S PREEMPTION CLAUSE TO ACHIEVE CONGRESS' INTENT OF UNIFORM ADMINISTRATION OF EMPLOYEE BENEFIT PLANS.

Although the Court has attempted to provide guidance in the area of ERISA preemption,[2] the lower courts are continuing to struggle with the boundaries of ERISA's preemption clause, particularly with the meaning of the phrase "relates to an employee benefit plan."[3] *Memorial Hospital System v. Northbrook Life Ins.*

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[2] *E.g., New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995); *John Hancock Mutual Life Ins. Co. v. Harris Trust and Savings Bank*, 510 U.S. 86 (1993); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *Massachusetts v. Morash*, 490 U.S. 107 (1988); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

[3] *See District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 135 n.3 (1992) (Steven J., dissenting) (noting that in December 1992, there were 2800 cases on LEXIS addressing ERISA preemption); *HealthAmerica v. Menton*, 555 So. 2d 235, 241 (Ala. 1989), *cert. denied*, 493 U.S. 1093 (1990) (White and O'Connor, JJ., dissenting to denial of *certiorari*); *see generally* C. L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 58-59 (1996) (footnotes omitted) ("The relatively large number of ERISA preemption opinions has not, however, led to clarity in the law. The lower courts have decided thousands of preemption cases, yet remain mired in confusion about basic points."); S. Stabile, *Preemption of State Law by Federal Law: A Task for Congress or the* (continued...)

Co., 904 F.2d 236, 244 (5th Cir. 1990). Indeed, more than one judge has expressed frustration with ERISA preemption and its impact. *See, e.g., United Wire and Machine Health and Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179, 1197 (3d Cir. 1993), *cert. denied*, 114 S. Ct. 382 (1993) (Nygaard, J. dissenting) ("ERISA could become a legal black hole with an attractive force no state law could resist."); *Jordan v. Reliable Life Ins. Co.*, 694 F. Supp. 822, 827 (N.D. Ala. 1988) ("The ERISA quicksand is fast swallowing up everything that steps in it or near it. This morass serves as the stage for a theater of the absurd."). And, this Court recently acknowledged its own frustration in its attempts to provide detailed guidance concerning ERISA preemption, *Travelers*, 115 S. Ct. at 1676, mainly because ERISA's preemption clause is not a "'model of legislative drafting and the legislative history . . . is sparse.'" *John Hancock Mutual Life Ins. Co. v. Harris Trust and Savings Bank*, 510 U.S. at 99 (*citing Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (*quoting Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)).

This Court's own experience with ERISA preemption illustrates the lower courts' struggle. The Court has issued twelve decisions on this issue, even though ERISA has been in effect for only twenty-one years. Roughly half of the cases which the Court has decided concerning ERISA have been preemption cases.[2] This term alone the Court has granted *certiorari* in three ERISA preemption cases.

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[3](...continued)
Courts?, 40 VILL L. REV. 1, 18 n. 42 (1995) (detailing the volume of cases and law review articles on ERISA preemption).

[2] C. L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 58-59 (1996), *cited with approval in Morstein v. National Ins. Services, Inc.*, 93 F.3d 715, 719 n. 7 (11th Cir. 1996).

Significantly, the federal courts are being inundated with preemption defenses in cases that have little to do with uniform administration of employee benefit plans or the protections offered by ERISA. This torrent of cases is due to the vague statutory language concerning the limits of ERISA's preemption clause and the perception that ERISA preemption can be used as both a sword and a shield to prevent participants from pursuing *bona fide* claims. *SeeRokohl v. Texaco*, 77 F.3d 126, 130 (5th Cir. 1996). ERISA's "unhelpful text" has resulted in a lack of uniformity on this issue, certainly undercutting Congress' objective in obtaining uniform administration of employee benefit plans and safeguarding participants' benefits. *Travelers*, 115 S. Ct. at 1677-78; *Massachusetts v. Morash*, 490 U.S. 107, 119 (1989). In order to produce more uniformity in the application of ERISA's preemption clause and to decrease the number of preemption cases in the federal courts, NELA respectfully suggests the adoption of a framework for analyzing ERISA preemption cases, which includes a more precise test for determining when a state law "relates to an employee benefit plan."

II. NEW YORK STATE'S LAW TAXING HOSPITALS IS NOT PREEMPTED BY ERISA BECAUSE THE LAW DOES NOT DIRECTLY CONFLICT WITH ERISA, DOES NOT DUPLICATE A CLAIM UNDER ERISA § 502, DOES NOT REFERENCE AN ERISA PLAN, AND IS A STATE LAW IN A TRADITIONAL AREA OF STATE REGULATION THAT NEITHER REGULATES AN ERISA-GOVERNED RELATIONSHIP NOR PRODUCES AN ACUTE INDIRECT ECONOMIC EFFECT.

A. ERISA Preemption Analysis Must Be Grounded In The Presumption That A State Law Is Not Preempted Unless Congress' Intent To Do So Is Clear.

ERISA preemption analysis is no different than any other preemption analysis. *John Hancock Mutual Life Ins. Co. v. Harris Trust and Savings Bank*, 510 U.S. at 99 ("we discern no solid basis for believing that, Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis"). As with other statutes, the Court has cautioned that, in order to avoid unintentionally encroaching on state authority, courts should be reluctant to find preemption when interpreting a federal statute. *Travelers*, 115 S. Ct. at 1676; *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) ("the historic police powers of the State [are] not to be superseded by...[federal law]"). Accordingly, "'the purpose of Congress is the ultimate touchstone of preemption analysis.'" *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992) (*quoting Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978) (*quoting Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103 (1963))); *see* U.S. CONST. art. VI, cl. 2.

"To discern Congress' intent we examine the explicit statutory language and the structure and purpose of the statute." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990). Congress explicitly stated its intent to preempt state laws in the statutory language of ERISA § 514(a), 29 U.S.C. § 1144(a). Section 514(a) states that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan" covered by the

statute. However, the language of ERISA § 514(a) does not provide a clear statement of how far Congress intended preemption to reach.

In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983), the Court explained that state law relates to an employee benefit plan "if it has a connection with or reference to such a plan." Nevertheless, the Court admonished that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n. 21. It follows that "relates to" must have some limitation, otherwise it "would never run its course." *Travelers*, 115 S. Ct. at 1677. To hold otherwise would be inconsistent with the presumption against preemption absent a clear indication of Congressional intent to do so, in order that state law is given the fullest effect possible. *Travelers*, 115 S. Ct. at 1676-78; *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 841 (1988).

In *Travelers*, 115 S. Ct. at 1677-78, the Court reviewed ERISA's structure and purpose to determine the purpose of the preemption clause and the limits of "relates to." The Court concluded that "the basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* Although the Court reiterated the presumption against preemption of state laws, the Court did not set forth any other framework for analyzing ERISA preemption. Consequently, this case and the others upon which *certiorari* has been granted presents the Court with the opportunity to establish a more workable framework for analyzing ERISA preemption cases including a more precise test for determining the boundaries of the phrase "relates to an employee benefit plan" in ERISA's preemption clause.

B. If A State Law Directly Conflicts With ERISA, It Must Be Preempted.

Under traditional preemption analysis, any state law that directly conflicts with a federal law, either on its face or in application, must be preempted. *Rice v. Santa Fe Elevator Corp.*, 331 U.S. at 230. Accordingly, state laws that (1) regulate the types of benefits or terms of a plan, *e.g., District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992) (workers' compensation law prohibiting termination of health benefits of workers receiving workers' compensation benefits is preempted); (2) create specific requirements as to funding, reporting and disclosure, vesting, and the like, *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir. 1978), *cert. denied*, 439 U.S. 831 (1978) (state law regulating funding and disclosure requirements of ERISA plans is preempted); and (3) establish rules for the calculation of benefits, *e.g., FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (interference with calculation of benefits through state antisubrogation statute); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (prohibition of offset of workers' compensation benefits against retirement benefits are preempted) are preempted. *See generally Airparts Company, Inc. v. Custom Benefit Services of Austin*, 28 F.3d 1062, 1064-65 (10th Cir. 1994); *Iron Workers Mid-South Pension Fund v. Terotechnology Corp.*, 891 F.2d 548, 553 (5th Cir. 1990), *cert. denied*, 497 U.S. 1024 (1990). These laws directly regulate ERISA plans and must be preempted. *Cf. Travelers*, 115 S. Ct. at 1683 (recognizing that laws having direct effects on plans are generally preempted).

NELA suggests that a determination whether the state law directly conflicts with ERISA should be the first step in any preemption analysis. If a state law conflicts with any provision of ERISA, then the state law is preempted and preemption analysis ends.

In this case, the New York law does not directly conflict with any provision of ERISA by regulating benefits, the terms of a plan, or calculation of benefits, or by creating any specific requirements

as to funding, reporting, disclosure, vesting, and the like, and we must go on to the next step of the preemption analysis.

C. If A State Law Claim May Be Brought Under ERISA §502(a), Then Such Claim Is Necessarily Preempted By ERISA § 514(a).

Where a state law claim can be brought under ERISA § 502(a) and thus is completely preempted under that section, *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987), it is necessarily preempted under ERISA § 514(a). *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (state law claim for bad faith denial of benefits preempted under ERISA § 514(a) because it would displace exclusive remedies under ERISA § 502(a)); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (state law action supplanted by ERISA § 510 as enforced via ERISA § 502(a) when ERISA offers same remedies).[10]

NELA suggests that a determination of whether a state law claim may be brought under ERISA § 502(a) should be the second step in the preemption analysis. If a state law claim may be brought under ERISA § 502(a), then it is preempted, and no additional preemption analysis is needed.

In this case, ERISA § 502(a) does not provide the State of New York with a cause of action to collect a tax, and thus the preemption analysis must continue.

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[10] Under this framework, the preemption analysis in *Ingersoll-Rand* and *Pilot Life* would end here. There would be no need to rely on a more general interpretation of ERISA § 514(a) as a basis for preemption.

D. Where A State Law Specifically Refers To An ERISA Plan, The State Law Relates To An Employee Benefit Plan And Is Preempted.

State laws that specifically reference ERISA plans are preempted to the extent they regulate ERISA plans. *Shaw*, 463 U.S. at 96-97. *Accord, District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992) (striking down District of Columbia law that "specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is preempted"); *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825 (1988) (a garnishment statute singling out ERISA plans for special treatment was held preempted, but the general garnishment statue was not preempted as applied to ERISA plans).

Thus, if a state law survives both conflict and complete preemption analysis (*see* II, B and II, C, *supra*), but specifically refers to an ERISA plan, it is preempted, and preemption analysis ends.

In this case, New York's law does not specifically reference ERISA plans, and we must proceed to the next step of the preemption analysis.

E. It Must Be Presumed That A State Law In An Area of Traditional State Regulation Is Not Preempted.

In analyzing preemption cases, the Court has consistently stated that state law is not to be preempted unless Congress' intent to do so is clear. *Travelers*, 115 S. Ct. at 1676; *Rice v. Santa Fe Elevator Corp.*, *supra* (the historic police powers of the State [are] not to be superseded by...[federal law]"); *Cipollone v. Liggett Group, Inc.*, *supra*. However, over the twenty-one years courts have interpreted ERISA's preemption clause, this presumption has been turned on its head. Instead, for many courts, the presumption has been that ERISA preempts state law claims.

It is clear that federal law generally should not have any preemptive effect on areas that states have historically regulated as "'to the protection of the lives, limbs, health, comfort, and quiet of all persons.'" *Slaughter-House Cases*, 33 U.S. 36, 16 Wall. 36, 62 (1872), *quoting Thorpe v. Rutland & Burlington R. Co.*, 27 Vt. 140, 149 (1855). These include: regulation of hospital costs, *Travelers*, 115 S. Ct. at 1681; "child labor laws, minimum and other wage laws, laws affecting occupational health and safety . . . ", *DeCanas v. Bica*, 424 U.S. 351, 356 (1976); laws abolishing or modifying the common law doctrines of common employment and assumption of the risk, *Howard v. Illinois Central Railroad Co.*, 207 U.S. 463 (1908); laws prescribing mandatory state holidays, payment for jury duty or time spent voting, *Day-Brite Lighting, Inc. v. Missouri*, 342 U.S. 421 (1952); legal malpractice claims, *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996); escheat of abandoned property, *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989); and enforcement of commercial contracts under common law, *Zuniga v. Blue Cross & Blue Shield of Michigan*, 52 F.3d 1395 (6th Cir. 1995). These laws concern issues that the states have historically regulated. This Court has made it clear that the states should be able to continue to regulate in these areas, unless there is clear Congressional intent to the contrary. *Travelers*, 115 S. Ct. at 1676.

Accordingly, a state law in an area of traditional state regulation will generally not be preempted unless it directly regulates an ERISA-governed relationship or attempts to do through indirect economic effect what it cannot do directly.

In this case, regulation of health care providers is a traditional exercise of state authority, *See Travelers*, 115 S. Ct. at 1676. Preemption analysis must continue with a presumption that the state law is not preempted.

F. If A State Law Regulates An ERISA-Governed Relationship, It Is Preempted.

State laws that regulate an ERISA-governed relationship -- between the plan and participants, the plan and the fiduciaries, the plan and the sponsoring employer, the fiduciaries or plan administrator and the participants, or the fiduciaries and the plan administrator[11/] -- will generally relate to an employee benefit plan, and therefore will be preempted. *Morstein v. National Ins. Services, Inc.*, 93 F.3d 715, 722-23 (11th Cir. 1996) (*en banc*); *Boyle v. Anderson*, 68 F.3d 1093, 1103 (8th Cir. 1995), *cert. denied*, 116 S.Ct. 1266 (1996); *Lordmann Enterprises, Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533-34 (11th Cir. 1994), *cert. denied*, 116 S. Ct. 335 (1995); *Travitz v. Northeast Dept. ILGWU Health & Welfare* Fund, 13 F.3d 704, 709 (3d Cir.), *cert. denied*, 114 S.Ct. 2165 (1994); *General American Life Ins. Co. v. Castonguay*, 984 F.2d 1518, 1521-22 (9th Cir. 1993); *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341,1344-45 (8th Cir. 1991), *cert. denied*, 504 U.S. 957 (1992); *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 249 (5th Cir. 1990); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1467-68 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 (1987); *cf. Pilot Life v. Dedeaux*, 481 U.S. at 53-54 (relationship between plan administrator and participant). State laws regulating these relationships are particularly likely to interfere with ERISA's regulatory scheme, and are presumptively preempted. *General American Life Ins. Co. v. Castonguay*, 984 F.2d at 1521-22.

11/ The relationship between the employer and employee is not an ERISA-governed relationship because that relationship concerns the employment relationship, not a relationship growing out of benefits. *Rokohl v. Texaco*, 77 F.3d 126, 130 (5th Cir. 1996); *Forbus v. Sears Roebuck & Co.*, 30 F.3d 1402, 1406-07 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 906 (1995). *cf. Variety Corp. v. Howe, supra* (where employer is held to be acting as a fiduciary, state law claims would be preempted).

Conversely, if the state law does not regulate an ERISA-governed relationship, it will not be preempted. For example, if the state law only regulates one of the principal ERISA entities, then there is no relationship, and there is no preemption. *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752, 753 (10th Cir. 1991) (a law affecting the relations between an ERISA entity and an outside party is not preempted). Quite simply, if there is no regulation of an ERISA-governed relationship, more likely than not, there will be no significant effect on the structure, administration, or the type of benefits provided by the plan. *Id.*

Moreover, if the principal ERISA entities are not being regulated in their ERISA capacities, then there is no ERISA-governed relationship. *Cf. John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. at 106 (where an insurance company is acting as an investment manager the insurance company must comply with fiduciary standards). Thus, "lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are against the plan in a capacity other than as a plan – *i.e.*, as a commercial entity – and are not preempted. *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 833 (1988). None of these claims concern the plan acting as an ERISA plan – that is, these claims do not impact plan administration or the payment of benefits. Where the plan is acting like a commercial entity and not like an ERISA plan, it should be treated the same as any commercial entity. *Id.; General American Life Ins. Co. v. Castonguay*, 984 F.2d at 1521-22.

This part of NELA's suggested framework is consistent with the Court's admonition in *Shaw*, because when a state law concerns a third party and therefore does not regulate an ERISA-governed relationship, the effect on employee benefit plans will be too tenuous or peripheral to find that it relates to a plan. Moreover, this prong is also consistent with Congress' objective to avoid multiplicity of regulation; obviously if a state law does not regulate an ERISA-governed relationship, there will not be duplicative regulation. *Travelers*, 115 S. Ct. at 1677-78. As a corollary, this

analysis is consistent with the presumption against preemption of state laws unless Congress' intent to do so is clear. *Id.* Finally, adoption of this part of NELA's suggested analysis will not require overturning any precedent; application of this test to past ERISA preemption cases would result in outcomes consistent with those decisions.

This analysis requires asking whether the state law reaches an ERISA-governed relationship -- that is, a relationship already regulated by ERISA. Accordingly, claims made against an employer in its corporate, rather than its fiduciary capacity, would not relate to employee benefit plans and would not be preempted. *Cf. Akers v. Palmer*, 71 F.3d 226 (6th Cir. 1995), *cert. denied*, 116 S. Ct. 2523 (1996) (decision to terminate plan is made in corporate capacity and thus claims are not preempted). A state law requiring a hospital to collect a surcharge from a participant would not be preempted because it regulates the hospital and the plan or its participants, and there is no ERISA-governed relationship. *Travelers*, 115 S. Ct. at 1680. Claims for medical malpractice against doctors would not be preempted because the doctor is not one of the principal ERISA entities. *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995). An individual's claim against an insurance agent and agency for fraudulent inducement to purchase and negligence in processing the application for an ERISA-governed insurance plan is not preempted because the relationship between the non-fiduciary agent (and agency) and the employee is not regulated by ERISA. *Morstein v. National Ins. Services, Inc.*, 93 F.3d 715, 722-23 (11th Cir. 1996) (*en banc*). A plan's malpractice claims against a service provider such as an attorney or actuary are not preempted because no ERISA-governed relationship is involved; the service provider is a non-fiduciary. *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996). Mere inclusion of a request for fringe benefits to fully compensate an employee for a wrongful discharge, otherwise unconnected to an employee benefit plan, would not be preempted because the crux of the claim is the wrongful termination of employment. *Forbus v. Sears Roebuck & Co.*, 30 F.3d 1402, 1406-07 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 906 (1995).

In *Boyle v. Anderson*, 68 F.3d 1093, the court reviewed a state statute similar to the one at issue in this case. The court found that the MinnesotaCare provider tax, permitting a health care provider to transfer the expense of a 2% provider tax to third party health care providers, did not change the structure or terms of the plan. Nor did it result in any alternation in the power or authority among the primary ERISA entities. Consequently the court held that these factors, among others, warranted a finding that the tax was not preempted.

Accordingly, NELA suggests that this prong of ERISA preemption analysis should be an inquiry as to whether the state law regulates an ERISA-governed relationship.[12]

In this instance, the New York state law does not regulate any ERISA-governed relationship. It does not regulate the relationship between the plan and its participants. It does not regulate the

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[12] A number of courts of appeals have formulated similar tests focusing on "principal ERISA entities" -- plan, participant, fiduciary, and employer. *Morstein v. National Ins. Services, Inc.*, 93 F.3d 715, 722-23 (11th Cir. 1996) (*en banc*); *Boyle v. Anderson*, 68 F.3d 1093, 1103 (8th Cir. 1995), *cert. denied*, 116 S.Ct. 1266 (1996); *Lordmann Enterprises, Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533-34 (11th Cir. 1994), *cert. denied*, 116 S. Ct. 335 (1995); *Travitz v. Northeast Dept. ILGWU Health & Welfare* Fund, 13 F.3d 704, 709 (3d Cir.), *cert. denied*, 114 S.Ct. 2165 (1994); *General American Life Ins. Co. v. Castonguay*, 984 F.2d 1518, 1521-22 (9th Cir. 1993); *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341,1344-45 (8th Cir. 1991), *cert. denied*, 504 U.S. 957 (1992); *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 249 (5th Cir. 1990); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1467-68 (5th Cir. 1986), *cert. denied*, 479 US 1034 (1987). While these tests are helpful in clarifying that cases involving third-parties are not preempted, they fail to recognize that employers and employees "wear more than one hat," that is, the employer has a relationship with the employee outside of its possible fiduciary role, which relationship has been regulated historically by the states. *E.g., DeCanas v. Bica*, 424 U.S. 351, 356 (1976).

relationship between the plan and the trustees. It does not regulate the relationship between the plan and the employer. It does not regulate the relationship between the participants and the trustees. New York's tax does not affect a participant's benefit eligibility or the calculation of benefits. Instead, it only regulates the plan in its commercial capacity as a health care provider. *See Travelers*, 115 S. Ct. at 1680. Consequently, under this prong of the analysis, New York state's law is not preempted.

G. If A State Law Accomplishes Through A Severe Indirect Economic Effect What It Could Not Do Directly, It Is Preempted.

As the final prong of preemption analysis, an inquiry must be made to ensure that the state is not accomplishing indirectly what it cannot do directly.

A state law taxing, or otherwise indirectly attempting through economics to effect, an ERISA plan generally will not be preempted because the economic effect will be so indirect that there will not be the requisite connection to an ERISA plan. *Travelers*, 115 S. Ct. at 1680. However, there may be instances where "a state law . . . produce[s] such acute, albeit indirect, economic effects . . . to force an ERISA plan to adopt a certain scheme of substantive coverage" or administration that the state law will be preempted. *Travelers*, 115 S. Ct. at 1683.

Thus, where the state law's indirect economic effect is so significant that it demonstrably and of necessity causes the plan to choose certain types of benefits; to change its terms; to create specific requirements as to funding, reporting and disclosure, vesting, and the like; or to establish rules for the calculation of benefits; or if the effect is to regulate an ERISA-governed relationship, it must be preempted. *See* II, B, and II, F, *supra*.

In this case, the New York state law's economic effect on ERISA plans is negligible, and thus is not preempted.

H. New York State's Law Taxing Gross Receipts From Patient Care Services Is Not Preempted Under Any Of The Steps In NELA's Suggested Framework For Analyzing ERISA Preemption Cases.

Accordingly, under NELA's suggested analysis, New York State's law taxing gross receipts from patient care services and general operations of all hospitals in New York does not directly conflict with ERISA, does not duplicate an ERISA claim under ERISA § 502(a), does not reference an ERISA plan, and is a state law in an area of traditional state regulation that does not directly regulate an ERISA-governed relationship and does not produce an acute demonstrable indirect economic effect on an ERISA plan. Thus, the state law does not "relate to an employee benefit plan", and it is not preempted under ERISA § 514(a), 29 U.S.C. § 1144(a).

CONCLUSION

For the foregoing reasons, NELA urges the Court to reverse the decision of the Second Circuit Court of Appeals.

Respectfully submitted,

Jeffrey Lewis
Sigman, Lewis & Feinberg
405 Fourteenth Street
Oakland, CA 94612

(510) 839-6824

Counsel for *Amicus Curiae*
National Employment
Lawyers Association

Mary Ellen Signorille
(Counsel of Record)
601 E Street, N.W.
Washington, DC 20049

(202) 434-2070

Counsel for *Amicus Curiae*
National Employment
Lawyers Association

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

vs.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE STATES OF CONNECTICUT, ET AL., AS AMICI CURIAE IN SUPPORT OF PETITIONERS

RICHARD BLUMENTHAL
Attorney General of Connecticut
Counsel of Record

PHYLLIS E. HYMAN
Assistant Attorney General
55 Elm Street
Hartford, Connecticut 06106
(860) 566-2026

(Additional Counsel Listed on Inside Cover)

38pp

GRANT WOODS
Attorney General
State of Arizona
1275 West Washington
Phoenix, Arizona 87005-2926

WINSTON BRYANT
Attorney General
State of Arkansas
200 Tower Building
323 Center Street
Little Rock, Arkansas 72201-2610

ROBERT A. BUTTERWORTH
Attorney General
State of Florida
The Capitol - PL-01
Tallahassee, Florida 32399-1050

MARGERY S. BRONSTER
Attorney General
State of Hawaii
Hale Auhau
425 Queen Street
Honolulu, Hawaii 96813

PAMELA CARTER
Attorney General
State of Indiana
219 Statehouse
Indianapolis, Indiana 46204

ANDREW KETTERER
Attorney General
State of Maine
6 State House Station
Augusta, Maine 04333

J. JOSEPH CURRAN, JR.
Attorney General
State of Maryland
200 Saint Paul Place
Baltimore, Maryland 21202-2021

SCOTT HARSHBARGER
Attorney General
Commonwealth of Massachusetts
One Ashburton Place
Boston, Massachusetts 02108

FRANK J. KELLEY
Attorney General
State of Michigan
P.O. Box 30212
Lansing, Michigan 48909

HUBERT H. HUMPHREY, III
Attorney General
State of Minnesota
Suite 1100
445 Minnesota Street
St. Paul, Minnesota 55101

MIKE MOORE
Attorney General
State of Mississippi
P.O. Box 220
Jackson, Mississippi 39205-0220

JEREMIAH W. (JAY) NIXON
Attorney General
State of Missouri
Supreme Court Building
207 West High Street
Jefferson City, Missouri 65101

JOSEPH P. MAZUREK
Attorney General
State of Montana
Justice Building
P.O. Box 201401
Helena, Montana 59620-1401

FRANKIE SUE DEL PAPA
Attorney General
State of Nevada
Capitol Complex
Carson City, Nevada 89710

JEFFREY R. HOWARD
Attorney General
State of New Hampshire
33 Capitol Street
Concord, New Hampshire 03301-6397

PETER VERNIERO
Attorney General
State of New Jersey
Richard J. Hughes Justice Complex
25 Market Street
Trenton, New Jersey 08625

W.A. DREW EDMONDSON
Attorney General
State of Oklahoma
2300 North Lincoln Boulevard
Suite 112
Oklahoma City, Oklahoma 73105-4894

THEODORE R. KULONGOSKI
Attorney General
State of Oregon
Justice Building
1162 Court Street, NE
Salem, Oregon 97310

THOMAS W. CORBETT, JR.
Attorney General
Commonwealth of Pennsylvania
16th Floor, Strawberry Square
Harrisburg, Pennsylvania 17120

JEFFREY B. PINE
Attorney General
State of Rhode Island
150 South Main Street
Providence, Rhode Island 02903

DAN MORALES
Attorney General
State of Texas
P.O. Box 12548
Austin, Texas 78711-2548

JEFFREY L. AMESTOY
Attorney General
State of Vermont
109 State Street
Montpelier, Vermont 05609-1001

JAMES S. GILMORE, III
Attorney General
Commonwealth of Virginia
900 East Main Street
Richmond, Virginia 23219

CHRISTINE O. GREGOIRE
Attorney General
State of Washington
1125 Washington Street
P.O. Box 40100
Olympia, Washington 98504-0100

DARRELL V. MCGRAW, JR.
Attorney General
State of West Virginia
State Capitol, Room E-26
Charleston, West Virginia 25305

JAMES E. DOYLE
Attorney General
State of Wisconsin
114 East, State Capitol
Madison, Wisconsin 53702

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42 U.S.C. § 1396b(w)(3)(C)(i)(III) (1994) 17

42 U.S.C. § 1396b(w)(7)(A) (1994). 18

42 U.S.C.§ 1396d(b) (1994). 18

42 U.S.C. § 1396r-4 (1994) 17

State Statutes

Ala. Code § 40-26B-21 (Michie, WESTLAW through 1996 2d Sp. Sess.) 15

Ariz. Rev. Stat. Ann. §§ 36-401 to -431.01 (West 1993 & Supp. 1996) 8

Cal. Health & Safety Code §§117600 - 118350 (Deering Special Pamphlet 1995) 8

Conn. Gen. Stat. § 12-263b, as amended by Pub. Act 96-144 15

Conn. Gen. Stat. §19a-491 (1995) 8

Conn. Gen. Stat. §19a-80 (1995) 9

Conn. Gen. Stat. §§51-80 to -88 (1995) 9

Fla. Stat. Ann. §§395.001, 395.1055 (West 1993 & Supp. 1996) 8

Fla. Stat. Ann. § 395.7015 (West, WESTLAW through 1995 1st Reg. Sess.) 15

Fla. Stat. Ann. §§402.302 to -.3125 (West 1993 & Supp. 1996) 9

Haw. Rev. Stat. § 346E-2 (Michie, WESTLAW through 1996 Reg. Sess.) 15

Ill. Comp. Stat. Ann. § 5/5A-2 (West's Smith-Hurd, WESTLAW through P.A. 89-505, apv. 6/28/96) 15

Ky. Rev. Stat. Ann. § 142.303 (Banks-Baldwin, WESTLAW through end of 1995 3d Ex. Sess.) 15

Me. Rev. Stat. Ann. tit. 22, § 391 (West, WESTLAW through 1995 1st Reg. Sess.) 15

Mass. Ann. Laws ch. 118 F, §15 (Law. Co-op. 1994 & Supp. 1996) 15

Minn. Stat. § 256.9657 (West, WESTLAW through 1996 Reg. Sess.) 16

Miss. Code Ann. § 43-13-145 (WESTLAW through 1995 Reg. Sess.) 16

Mo. Rev. Stat. § 208.453 (West, WESTLAW through 1995 1st Reg. Sess.) 16

Mont. Code Ann. § 15-60-102 (WESTLAW through 1995 Reg. Sess.) 16

N.H. Rev. Stat. Ann. §§151:1 to -:9 (1996) 8

N.H. Rev. Stat. Ann. § 84-A:2 (WESTLAW through 1995 Reg. Sess., ch. 309, apv. 7/3/95) 16

N.H. Rev. Stat. Ann. §§311:1 to -:13 (1995 & Supp. 1995) 9

N.Y. Pub. Health Law § 2807-a (23) - (27) (McKinney 1993 and Supp. 1996) 16

Okla. Stat. Ann. tit. 5 §§1 - 18 (West 1996 & Supp. 1997) 9

R.I. Gen. Laws §§23-19.12-1 to -19 (Supp. 1995) 8

R.I. Gen. Laws § 44-51-3 (Michie, WESTLAW through 1995 Reg. Sess.) 16

S.C. Code Ann. § 12-23-810 (WESTLAW through 1995 Reg. Sess.) 16

S.C. Code Ann. §§44-93-10 to -240 (Law. Co-op. Supp. 1995) 8

Tenn. Code Ann. § 68-11-216(d) (WESTLAW through 1996 2d Reg. Sess.) 16

Texas Health & Safety Code Ann. §241.001 to -.029 (West 1992 & Supp. 1997) 8

Utah Code Ann. § 26-36-105 (Michie, WESTLAW through 1996 2d Sp. Sess.) 16

Vt. Stat. Ann. tit. 33 §§ 1950-1958 (Supp. 1996) 16

Wash. Rev. Code Ann. §§74.15.010 to -.200 (West 1982 & Supp. 1996) 9

W.Va. Code §§ 11-27-9, 11-27-15 (Michie, WESTLAW through 1996 Reg. Sess.) 16, 17

Wis. Stat. Ann. § 50.14 (West Supp. 1995) 17

Wis. Stat. Ann. §§757.293, -.295, -.30 (West 1981 & Supp. 1995) 9

State Rules and Regulations

Conn. Agencies Regs. §19-13-D8t (1995) 8

Conn. Agencies Regs. §§19a-79-1a to -12 (1993) 9

Fla. Admin. Code Ann. r. 10M -12.001 to -12.014 (1995) 9

N.H. Code Admin. R. Ann. He-p 801.02 to 803.11 (1996) 8

Other Authorities

Patricia Butler & Elizabeth Mitchell, *Health Care Provider Networks: Regulatory Issues for State Policy Makers* 1 (February 1996) 11

Tom Christoffel, *Health and the Law* 148 (1982) 10

Deborah Cowans, *Interest in Employer-Sponsored Clinics Grows*, Business Insurance, February 21, 1994 at 3 7

Dick Dahl, *Lawyers Find Opportunity in Prepaid Legal Plans*, Lawyers Weekly USA, October 1993, at 1-11 8

Jonathan Harris, *On Site Health Clinics*, The Self-Insurer, January 1995 at 7 7

How One Employer Implemented On-Site Child Care, Employee Benefits Management Directions (CCH), July 11, 1995 7

Karen Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-Emption*, 13 Yale J. on Reg. 255 (1996) 10, 11, 12

Robert Kazel, *New York Life Sets Up Backup Care Center*, Business Insurance, November 13, 1995 7

Louise Kertesz, *Employers, Insurers Center Attention on Primary Care*, Modern Healthcare, June 19, 1995 at 136 7

On-Site Day Care for D.C. Law Firm Receives Favorable Verdict, Employee Benefit News, February 1995 at 55 7

Robert Pear, *HMO's Using Federal Law to Deflect Malpractice Suits*, N.Y. Times, November 17, 1996 at 24 12

Walter Schuler, Note, *The ERISA Pre-Emption Narrows: Analysis of New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company and Its Impact on State Regulation of Health Care*, 40 St. Louis Univ. L.J. 783, 815-822 (1996). 20

Seema Shah, Comment, *Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to Pacificare of Oklahoma v. Burrage*, 80 Minn. L. Rev. 1545 (1996) 11

No. 95-1594

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners

against

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents

On Writ Of Certiorari To The United States Court of Appeals For The Second Circuit

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BRIEF FOR THE STATES OF CONNECTICUT, et al. AS AMICI CURIAE IN SUPPORT OF PETITIONERS

STATEMENT OF INTEREST

The amici curiae states, through their attorneys general, respectfully submit this brief in support of Petitioners. Amici support reversal of the holding of the Second Circuit Court of Appeals, in *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 74 F.3d 28 (2d Cir. 1996), that New York's 0.6% Health Facility Assessment ("HFA"), as applied to an ERISA-owned and operated health facility, is preempted by ERISA.

The amici states have a strong interest in the ERISA preemption issues raised in this case. It is critical to the states that the scope of ERISA preemption be contained within its proper ambit so as not to interfere with the states' ability to regulate all providers of health care services, without regard to whether the health care provider is owned and operated by an ERISA plan.

This Court's decision in *New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Company*, 115 S. Ct. 1671 (1995)("Travelers") established that ERISA does not preempt state laws of general applicability that have the effect of increasing ERISA plan costs of purchasing health services for their participants and beneficiaries. Such economic impact, because it neither forces ERISA plans to adopt a certain scheme of substantive coverage nor restricts plans' choices of insurers, is insufficient to trigger ERISA preemption. Moreover, state laws of general applicability that regulate health care provider services, as opposed to core ERISA plan functions, should not be considered preempted when incidentally applied to health care providers owned and operated by ERISA plans.

In the case below, the Second Circuit held that, even when the effect of a state tax of general applicability was merely economic and did not restrict plan choices or activities, it was preempted because there was no third party

between the plan and the tax imposed. *NYSA-ILA*, 74 F.3d at 30. Based solely on the fact that the health facility was owned and operated by an ERISA plan, the Second Circuit held that New York's HFA, a state law of general applicability, was preempted as to this facility on the ground that the economic effect was "direct," with an immediate effect on the ERISA plan.

This reasoning depends on an artificial distinction that is inconsistent with the principles underlying this Court's decision in *Travelers*. As a practical matter, it also impinges on the states' ability to implement legislative solutions in areas of traditional state power. ERISA plans increasingly are choosing to provide health care and day care services to their participants and beneficiaries, rather than pay other entities to provide these services. ERISA plans are also property owners, consumers and employers that, up until now, have been subject to the same state taxes of general applicability as any other entity. In addition, new and complex forms of health care delivery systems are emerging that may be owned and operated, in whole or in part, by ERISA plans. The states' authority to tax and regulate all these entities and providers of service must not be limited by their identification as ERISA-owned and operated.

Furthermore, if ERISA-owned and operated health care facilities are exempt from the application of state health care related taxes enacted by states in accordance with federal Medicaid law, states will be precluded from obtaining the maximum federal matching funds. The states' efforts to assist hospitals with their uncompensated care costs will also be hampered if their health care related taxes are not applied to all health care facilities within a designated class.

The Second Circuit's adoption of the distinction between a direct economic effect (where there is no third party between the plan and the tax) and an indirect effect

(where the tax is on a third party and passed through to the plan) is thus of great concern to the amici states. It places the states on a slippery slope that ultimately threatens both to block appropriate state regulation of quality health care and interfere with states' efforts to initiate health care reform. States' regulation of health care and their general authority to tax must not be set by the organizational choices of ERISA plans. In fact, such a result would give ERISA plans an unintended and unwarranted competitive advantage in providing tax exempt and unregulated health care services.

SUMMARY OF ARGUMENT

The Second Circuit Court of Appeals erroneously concluded that a 0.6% state tax of general applicability, when imposed on a health facility owned and operated by an ERISA plan, is preempted by ERISA. The correct inquiry, under *Travelers*, is whether a state law operates in such a manner that it dictates or restricts an ERISA plan's benefit structure or administration. A law of general applicability that has a mere economic influence on an ERISA plan, whether directly or indirectly applied to an ERISA plan, is clearly not preempted. Nor should a law of general applicability that affects the operation of ERISA plans in their capacity as providers of health care services, as opposed to their capacity as ERISA plan administrators, be preempted.

States must not be precluded from exercising their traditional authority in the area of health care regulation in a uniform manner as to all health care providers that provide similar services. The Second Circuit's decision would prohibit regulation of plan-owned health care facilities, including requirements for licensure and compliance with health and environmental laws, since such regulation does ultimately impose costs on plan-owned facilities.

If plan-owned and operated facilities are exempt from state public health regulations, facilities that are not currently owned and operated by ERISA plans will look for a way to reorganize themselves to avoid such regulation. Similarly, more ERISA plans will choose to provide services themselves instead of funding the purchase of services. A large percentage of health care services, therefore, will become unregulated, a result contrary to sound public policy and which would threaten the health and safety of residents of the states.

As new forms of health care delivery arrangements emerge, states must have the flexibility and authority to regulate providers of services, regardless of whether the provider happens to be owned and operated by an ERISA plan. ERISA preempts state laws that impose obligations on the administrative practices of plans when they function as plans, not when they function as providers of services that are subject to generally applicable state laws.

Supreme Court precedent, in both *Travelers* and *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), supports a reversal of the Second Circuit's decision. This Court has held that the operation of a generally applicable statute, directly on ERISA plans, does not result in preemption, even though the burdens associated with the statute are imposed on the plans. In *Travelers*, this Court emphasized that if a state law of general applicability in the health care field does not mandate benefits, bind plan administrators to any particular choice, or preclude the uniform administrative practices of a plan, the law will not be preempted by ERISA. If ERISA plans choose to provide services that are the subject of traditional state regulation, it is critical that states have the authority to tax and regulate them as they would any other provider of services.

ARGUMENT

I. THE SECOND CIRCUIT'S PREEMPTION ANALYSIS IN *NYSA-ILA* THREATENS THE STATES' ABILITY TO PROTECT THE PUBLIC HEALTH AND WELFARE

As a result of *Travelers*, it is now firmly established that state laws regulating in the area of health care may have an economic effect on choices made by ERISA plans, without being preempted by ERISA. *Travelers*, 115 S. Ct at 1679. This Court reasoned that such economic influence "does not bind plan administrators to any particular choice and thus function as a regulation of the ERISA plan itself." *Id.* Significantly, the Court noted that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 115 S. Ct. at 1680. Yet the Second Circuit held that New York's HFA is invalid when an ERISA plan owns or operates a facility simply because, in such a case, the impact on the ERISA plan is "direct."[1/]

[1/] The Second Circuit's decision uses the term "direct economic impact" to distinguish it from what this Court referred to in *Travelers* as an "indirect" economic effect. We point out that the words "direct" and "indirect" appear to be terms of art that are not used consistently. For example, in *Travelers*, this Court referred to the economic effect on ERISA plans in *Mackey*, as "indirect," even though the garnishment statute in that case imposed administrative costs and burdens directly on the ERISA plans, without a third party between the plan and the garnishment. *See Travelers*, 115 S.Ct. at 1680. In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981), this Court characterized a statute

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This rationale undermines this Court's holding that ERISA does not displace local health care regulation and spells disaster for the states.

A. States Will be Precluded from Regulating the Increasing Number of Facilities Owned and Operated by ERISA Plans.

Although the *NYSA-ILA* decision may be a case about the validity of a health care tax, ultimately at issue here is also the validity of public health regulations that are imposed uniformly on health care facilities, regardless of the ERISA-status of the owners and operators of the facilities. As with taxes, state public health regulations increase the cost of doing business for health care facilities. Consequently, if state tax laws are preempted as to ERISA-owned entities, state public health laws will also be preempted.

The employee benefits literature is replete with references to the trend toward employer-sponsored facilities

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that banned pension benefit offsets as having an "indirect" effect, even though it applied directly to a calculation technique. Similarly, in *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989), the Second Circuit characterized a state escheat tax of general applicability as "indirect" despite the fact that the law required payment from and imposed costs on an ERISA plan. The use of the term "indirect" in these contexts appears to refer to the fact that the ERISA plans are neither singled out for imposition of the tax nor the intended target of the tax. The tax is levied on them incidentally through general application of the law.

offering services covered under employee benefit plans. *See, e.g.*, Louise Kertesz, *Employers, Insurers Center Attention on Primary Care*, Modern Healthcare, June 19, 1995 at 136. ("Employer and insurer-sponsored primary health care centers continue to multiply ... The business of providing directly contracted health care services to the business community is burgeoning..."); Jonathan Harris, *On Site Health Clinics*, The Self-Insurer, January 1995 at 7 ("[E]mployer-sponsored health care systems have gained in popularity as employers continue their attempts to control health care costs."); Deborah Cowans, *Interest in Employer-Sponsored Clinics Grows*, Business Insurance, February 21, 1994 at 3 ("[M]ore and more employees are taking the ultimate step in managed care: operating their own medical centers. . . . [H]ealth care management companies say that inquiries about forming new employer-sponsored health centers are streaming in."). In an attempt to cut costs and improve accessibility of health care to their employees, many companies, instead of self-insuring or funding benefits through the purchase of insurance, are offering health services themselves.

Similarly, many employers and ERISA plans are now operating on-site day care centers for their employees and their young children, instead of subsidizing the purchase of these services from other providers. They find that this arrangement results in increased productivity, improved employee morale, and more effective retention and recruitment of professionals. *See, e.g., On-Site Day Care for D.C. Law Firm Receives Favorable Verdict*, Employee Benefit News, February 1995 at 55; *How One Employer Implemented On-Site Child Care*, Employee Benefits Management Directions (CCH), July 11, 1995; Robert Kazel, *New York Life Sets Up Backup Care Center*, Business Insurance, November 13, 1995.

Legal services are another employee benefit that may be covered by ERISA plans. 29 U.S.C. § 1002(1)

(1988). Employer-sponsored, prepaid legal services are growing in popularity among large corporations and unions. Dick Dahl, *Lawyers Find Opportunity in Prepaid Legal Plans*, Lawyers Weekly USA, October 1993, at 1-11.

Under the Second Circuit's decision, if state regulations, which apply to all health care providers, all day care centers and all legal practices, are imposed on an ERISA plan by virtue of the ERISA plan's operation as a provider of services, the state regulations will be preempted. The consequences for the general public would be dramatic.

States, as part of their traditional functions, regulate health care facilities in an attempt to ensure at least a minimum of quality health care for their residents. For example, hospitals and nursing homes must meet specific licensure requirements that are essential to the protection of the public health. They are required, among other things, to maintain minimum standards for ratios of patients to registered nurses, infection control activities, sanitary conditions, dietary and laundry services and maintenance of medical records. *See, e.g.*, Ariz. Rev. Stat. Ann. §§ 36-401 to -431.01 (West 1993 & Supp. 1996); Conn. Gen. Stat. §19a-491 (1995); Fla. Stat. Ann. §§395.001, 395.1055 (West 1993 & Supp. 1996); N.H. Rev. Stat. Ann. §§151:1 to -:9 (1996); Texas Health & Safety Code Ann. §241.001 to -.029 (West 1992 & Supp. 1997); Conn. Agencies Regs. §19-13-D8t (1995); N.H. Code Admin. R. Ann. He-p 801.02 to 803.11 (1996). States also impose strict standards concerning the disposal of medical waste to protect patients, employees and the general public from unsanitary and dangerous conditions. *See, e.g.*, Cal. Health & Safety Code §§117600 - 118350 (Deering Special Pamphlet 1995); R.I. Gen. Laws §§23-19.12-1 to -19 (Supp. 1995); S.C. Code Ann. §§44-93-10 to -240 (Law. Co-op. Supp. 1995). It is clear, therefore, that, following the Second Circuit's reasoning in *NYSA-ILA*, a wide range of public health regulations would be preempted as to

ERISA-owned facilities because they increase the costs of operation of the facilities. As this Court noted in *Travelers*, 115 S.Ct at 1679, "[t]he bigger the package of regulation with indirect effects that would fall on [the ERISA plans'] reading of [the ERISA preemption clause], the less likely it is that federal regulation of benefit plans was intended to eliminate state regulation of health care costs."

States also regulate extensively the operation of all day care centers. They tend to be rigorous in their efforts to ensure that children will be cared for in a safe, healthy and nurturing environment, and that the staff that cares for the children has the necessary qualifications. *See e.g.*, Conn. Gen. Stat. §19a-80 (1995); Fla. Stat. Ann. §§402.302 to -.3125 (West 1993 & Supp. 1996); Wash. Rev. Code Ann. §§74.15.010 to -.200 (West 1982 & Supp. 1996); Conn. Agencies Regs. §§19a-79-1a to -12 (1993); Fla. Admin. Code Ann. r. 10M -12.001 to -12.014 (1995). Under *NYSA-ILA*, these laws, too, would be preempted. Similarly, for ERISA-owned and operated legal plans, the practice of law and lawyers who work for such plan-sponsored legal services would also be exempt from state statutes and regulations governing them and their practices. *See, e.g.*, Conn. Gen. Stat. §§51-80 to -88 (1995); N.H. Rev. Stat. Ann. §§311:1 to :13 (1995 & Supp. 1995); Okla. Stat. Ann. tit. 5 §§1 to 18 (West 1996 & Supp. 1997); Wis. Stat. Ann. §§757.293, -.295, -.30 (West 1981 & Supp. 1995).

As acknowledged in *Travelers*, state regulation, such as quality control and workplace regulation, will inevitably affect what an ERISA plan can afford or get for its money. *Travelers*, 115 S.Ct at 1679. Moreover, to the extent the regulated provider of services is owned and operated by an ERISA plan, the plan will argue that regulation of that provider is a "direct" effect on the plan itself and is therefore preempted. There is no evidence, however, that Congress intended that ERISA should be applied to prevent states from setting standards for the

quality of services rendered to residents in areas of traditional state regulation, merely because the service is provided by an ERISA benefit plan.

B. States Need Flexibility to Regulate Emerging and Innovative Forms of Health Care Delivery Systems

At issue also is the states' ability to regulate the delivery of health care services by new and sometimes complex business arrangements. States must retain the authority to protect the public concerning issues of access and quality of services. If an ERISA plan chooses to own and operate a health care provider network, this should not preclude the states from regulating it.

When ERISA was enacted in 1974, the health care industry was significantly different from what it is today. Health insurance was provided either through a traditional indemnity plan, or employers were self-insured. Karen Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-Emption*, 13 Yale J. on Reg. 255, 302 (1996) [hereinafter Jordan Article]. Congress had just enacted the Health Maintenance Organization ("HMO") Act of 1973, 42 U.S.C. § 300e (1994), in an attempt to contain costs and spur competition in the health care field.[2/] The ramifications of managed care[3/] and the use of provider networks,[4/] however, were

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[2/] Tom Christoffel, *Health and the Law* 148 (1982)

[3/] A broad definition of managed care encompasses the combination of health care financing and delivery functions within a single entity, focusing on cost and utilization control. The purpose of utilization review is

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not foreseeable at that time. Issues concerning participation in these networks and utilization review were not in the minds of lawmakers or policymakers.[5/] Congress could not possibly have contemplated that the ERISA preemption clause might be used to prevent states from exercising their traditional authority to regulate these new health care delivery arrangements.

Under managed care, instead of merely reviewing and paying for participants' health care, many HMOs, as providers of medical services, enter into contracts with provider groups or networks, or hire their own health care professionals to provide medical services. Shah Article, *supra* note 3 at 1550. ERISA plans, in turn, may enter into contracts with provider networks or with HMOs to provide health care services for their participants. In some cases, ERISA plans own and operate their own HMOs. Further, a third-party administrator with whom an employer may

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to ensure that patients receive only those medical services that are actually needed. Seema Shah, Comment, *Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to Pacificare of Oklahoma v. Burrage*, 80 Minn. L. Rev. 1545, 1548-9 (1996) [hereinafter Shah Article].

[4/] Provider networks are joint ventures among health care providers which are known by many names, such as provider-sponsored networks, integrated delivery systems or organized delivery systems. They are formed for the purpose of contracting with health care purchasers. Patricia Butler & Elizabeth Mitchell, *Health Care Provider Networks: Regulatory Issues for State Policy Makers* 1 (February 1996) (prepared for the National Academy for State Health Policy)

[5/] Jordan Article at 322.

contract may also be part of an integrated network and provide management services for the network.

In deciding whether a statute is preempted by ERISA, as impermissibly infringing on the "administration of the ERISA plan," courts must distinguish carefully between the practices that pertain to claims management, which are an integral part of ERISA plan operations, and practices that concern the network as a business or provider, which are not ERISA plan functions. *See generally* Jordan Article at 324-332 . State laws that interfere with the operation of ERISA plans' benefit and eligibility determinations should be preempted. State laws that affect ERISA plans in their capacity as medical services providers or as other business entities operating in the health care field, however, should not be preempted. *See Varity Corp. v. Howe*, 116 S.Ct. 1065, 1071 (1996) (recognizing that ERISA plans function in different capacities and that only certain ERISA plan activities involve plan administration or management and are subject to ERISA). *See also* Robert Pear, *HMO's Using Federal Law to Deflect Malpractice Suits*, N.Y. Times, November 17, 1996 at 24 (HMOs are arguing that they are protected from malpractice claims and lawsuits by ERISA). Although state laws that impose obligations on health care providers and businesses may result in increased costs to ERISA plans, they do not bind administrative decisions concerning core ERISA plan functions. Under *Travelers*, therefore, such state laws are valid as to all providers of services.

C. The States' Ability to Impose All Taxes of General Applicability Should Not Be Preempted

New York's HFA is imposed on all health centers as providers of care, not as ERISA plans. Imposition of the assessment has an economic effect that is applied to all

medical centers, without respect to whether they are operated by ERISA plans. The assessment, therefore, is purely economic in effect and is not targeted at ERISA plans. It has no direct relationship to the operation or administration of the ERISA plan itself. Pursuant to this Court's reasoning in *Travelers*, such a law clearly is not subject to ERISA preemption.

The power to tax is a traditional state function. Federal courts must give due respect to "the fundamental principle of comity between federal courts and state governments that is essential to 'Our Federalism,' particularly in the area of state taxation." *Fair Assessment in Real Estate Ass'n v. McNary*, 454 U.S. 100, 103 (1981). Without their ability to impose a wide variety of taxes for the purpose of raising revenues, states will be crippled in their efforts to provide all manner of services to their residents. ERISA should not be interpreted to interfere with states' general taxation authority, simply because there is an incidental economic effect on an ERISA plan. It is this principle that is clearly reflected in the *Travelers* decision.

In stark contrast to this principle, under the Second Circuit's reasoning in this case, state laws of general applicability, such as real estate taxes, sales taxes and unemployment taxes, if applied directly to an ERISA plan, would be preempted. An ERISA plan could potentially transfer real property within a state and avoid paying the same tax that all other property owners are responsible for paying. *See Morgan Guaranty Trust Co. v. Tax Appeals Tribunal*, 80 N.Y. 2d 44, 599 N.E. 2d 656 (1992) (pre-*Travelers* decision exempting an ERISA plan that owned and transferred property from payment of state real property transfer tax). Similarly, an ERISA plan with employees could also be exempt from paying state unemployment taxes for its employees and could avoid paying state sales taxes for its purchases of goods and services. Such an untenable result was not intended by

Congress when it enacted ERISA's preemption clause. *See Travelers*, 115 S.Ct. at 1677, 1683 (concluding from legislative history and from language in *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 142 (1990) that Congress intended to eliminate conflicting or inconsistent state regulations of employee benefit plans, not eliminate state laws in areas traditionally subject to local regulation). The HFA is entirely neutral, applying to all hospitals and health care providers in New York, not just those operated by ERISA plans. As the Second Circuit noted in *Rebaldo v. Cuomo*, 749 F.2d 133, 138,139 (2d Cir.), *cert. denied*, 472 U.S. 1008 (1985), Congress did not intend to permit ERISA plans to live a "charmed existence." ERISA plans must not be permitted to operate in a "fully insulated legal world" that exempts them from state laws of general applicability that only incidentally affect them.

D. The States Will Be Hampered in Their Efforts to Generate Funding Through Federally Authorized Health Care Related Taxes

Certain state taxes, in addition to being imposed pursuant to the states' general taxing authority, are also specifically recognized by Congress as a legitimate exercise of that authority. Federal Medicaid[6/] law explicitly

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[6/] Medicaid is a program of "cooperative federalism," whereby the cost of providing "medical assistance" is shared by the state and federal governments. Federal law sets forth the requirements that must be met by states as candidates for receiving partial federal financial participation for the cost of the program. 42 U.S.C. §

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acknowledges that states may apply their existing, standard taxes, such as sales taxes, to the provision of health care services. 42 U.S.C. §1396a(t) (1994). In addition, Congress specifically authorized health care provider taxes, 42 U.S.C. §1396b(w)(3) (1994), as a means for states to raise revenues. Many states have enacted one or both of these taxes.[7/]

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1396a (1994).

[7/] *See* Ala. Code § 40-26B-21 (Michie, WESTLAW through 1996 2d Sp. Sess.) (imposing "providers of medical services privilege tax" on nursing facilities); Conn. Gen. Stat. § 12-263b, as amended by Pub. Act 96-144 (West, WESTLAW through 1996 Reg. Sess.) (tax on "hospital gross earnings of each hospital"); Fla. Stat. Ann. § 395.7015 (West, WESTLAW through 1995 1st Reg. Sess.) (imposing 1.5% assessment on annual net operating revenues of certain "health care entities"); Haw. Rev. Stat. § 346E-2 (Michie, WESTLAW through 1996 Reg. Sess.) (taxes of 6% and 4% imposed on "nursing facility income" and "hospital income" respectively); Ill. Comp. Stat. Ann. § 5/5A-2 (West's Smith-Hurd, WESTLAW through P.A. 89-505, apv. 6/28/96) (assessment of 1.88% of "adjusted gross hospital revenue" of "each hospital provider"); Ky. Rev. Stat. Ann. § 142.303 (Banks-Baldwin, WESTLAW through end of 1995 3d Ex. Sess.) (2.5% tax on gross revenues of providers "for the provision of hospital services"); Me. Rev. Stat. Ann. tit. 22, § 391 (West, WESTLAW through 1995 First Reg. Sess.) (assessment of 0.15% of hospital's "gross patient service revenues"); Mass. Ann. Laws ch. 118 F, §15 (Law. Co-op. 1994 &

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Supp. 1996) (hospital assessments); Minn. Stat. § 256.9657 (West, WESTLAW through 1996 Reg. Sess.) (assessment on hospital revenues, nursing home beds and HMOs); Miss. Code Ann. § 43-13-145 (WESTLAW through 1995 Reg. Sess.) (assessment on nursing homes of two dollars per bed per day); Mo. Rev. Stat. § 208.453 (West, WESTLAW through 1995 1st Reg. Sess.) (hospitals pay "federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care"); Mont. Code Ann. § 15-60-102 (WESTLAW through 1995 Reg. Sess.) ($2.80 "utilization fee" paid by each "nursing facility" for "each bed day in the facility"); N.H. Rev. Stat. Ann. § 84-A:2 (WESTLAW through 1995 Reg. Sess., ch. 309, apv. 7/3/95) (Medicaid Enhancement Tax "at a rate to be established by the legislature each biennium upon the gross patient services revenue of every hospital"); N.Y. Pub. Health Law § 2807-a (23) - (27) (McKinney 1993 and Supp. 1996) (assessment on hospital revenues); R.I. Gen. Laws § 44-51-3 (Michie, WESTLAW through 1995 Reg. Sess.) (assessment of 3.75% on "gross patient revenue received by every nursing facility"); S.C. Code Ann. § 12-23-810 (WESTLAW through 1995 Reg. Sess.)(hospital tax based on total expenditures of each hospital as a percentage of total hospital expenditures state-wide); Tenn. Code Ann. § 68-11-216(d) (WESTLAW through 1996 2d Reg. Sess.) (annual nursing home tax); Utah Code Ann. § 26-36-105 (Michie, WESTLAW through 1996 2d Sp. Sess.) (Medicaid Hospital Provider Temporary Assessment imposed on hospitals' "audited gross inpatient revenues"); Vt. Stat. Ann. tit. 33 §§ 1950-1958 (Supp. 1996); W.Va. Code §§ 11-27-9,

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In most of these states, the revenue raised through these taxes is used by the state to make disproportionate share hospital ("DSH") payments to hospitals. 42 U.S.C. § 1396r-4 (1994). These payments help hospitals cover the costs of providing care to patients who are either uninsured or underinsured, and whose care would be provided by hospitals as uncompensated care. For inner-city hospitals with extremely high levels of uncompensated care, these DSH payments may make the difference between bankruptcy and survival. The same is true in rural Appalachian areas. Thus, it is economically depressed areas that would suffer most if DSH payments to hospitals must be reduced or eliminated.

A health care related tax is defined as "a tax . . . that -- is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services." 42 U.S.C. § 1396b(w)(3)(A)(i) (1994). Contemplated health care related taxes include "taxes based on revenues or receipts." 42 U.S.C. § 1396b(w)(3)(C)(i)(III) (1994). In order to be a qualifying health care related tax, the tax must meet specified criteria; one of these is that the tax must be imposed *uniformly* with respect to a class of providers of services. *Id.* In-patient hospital services, out-patient hospital services, nursing facility services, and services of health maintenance organizations are examples of "classes" of providers. 42 U.S.C. § 1396b(w)(7)(A) (1994).

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11-27-15 (Michie, WESTLAW through 1996 Reg. Sess.) (health care provider tax of 2.5% of gross receipts on providers of "inpatient hospital services" and "outpatient hospital services"); Wis. Stat. Ann. § 50.14 (West Supp. 1995) (assessment on "occupied, licensed beds" of nursing home facilities).

If ERISA preemption is construed to invalidate health care related taxes as applied to ERISA-owned and operated providers of a class of health care services, merely because a health care provider is an ERISA plan, a state's health care related tax will no longer be "uniform" and "broad-based." Federal law provides that if a state's health care related tax is not broad-based, the total amount expended by the state through its Medicaid program as "medical assistance," which would normally be matched by the federal government, is reduced by the sum of the revenues obtained from the health care related tax. 42 U.S. C. § 1396b(w) (1994). Consequently, if ERISA-owned facilities are exempt from the taxes, the result could be a loss of federal matching funds to the states. The impact will be greatest in the poorer states, i.e., those states that have low per capita incomes, and are least able to meet the health care needs of their residents. These states have higher "federal medical assistance percentages" and thus will suffer disproportionately from the impact of this decision. *See* 42 U.S.C.§ 1396d(b) (1994).

Moreover, for the states that use the revenue from their health care related taxes to make DSH payments to hospitals, which also qualify for matching federal funds, there are losses on two levels: first, less revenue is raised and redistributed to the hospitals because ERISA-owned entities are exempt from the taxes; second, the states are eligible for fewer matching dollars because the DSH payments will not be as great.

It defies logic that Congress would enact specific criteria that, if met, provide the states with an effective way to raise revenue and assist hospitals with their uncompensated care costs, and that ERISA would operate to make it impossible for the states to take advantage of that provision. ERISA should be interpreted to be consistent with other federal law. *See Travelers*, 115 S.Ct. at 1682 (ERISA's preemption clause should not be interpreted so

broadly as to render another federal law, enacted after ERISA, "utterly nugatory."). *See also* 29 U.S.C. § 1144(d) (1988) (ERISA shall not be construed to invalidate or impair the operation of any other federal law).

II. THE SECOND CIRCUIT'S ANALYSIS IN *NYSA-ILA* IS INCONSISTENT WITH THIS COURT'S DECISIONS IN *MACKEY* AND *TRAVELERS*

The *Travelers* decision clarified that this Court was unwilling to apply an unduly broad ERISA preemption analysis to state laws of general applicability in the health care area simply because of the ambiguity of the "relate to" language in ERISA. Rather, this Court understood the need to go beyond the language in ERISA and look to the objectives of the ERISA statute "as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 115 S. Ct at 1677.

> [W]e have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress did not intend to supplant state law (citation omitted). Indeed, in cases like this one, where federal law is said to bar state action in fields of traditional state regulation, see *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 719, 105 S.Ct 2371, 2378 . . . (1985), we have worked on the "assumption that historic police powers of the States were not to be superseded by [ERISA] unless that was the clear and manifest purpose of Congress."

Travelers, 115 S.Ct at 1676 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). It is true that the precise holding in *Travelers* addresses the validity of a hospital surcharge that had only an "indirect" economic effect on ERISA plans, i.e., the tax was imposed on patient charges that were potentially paid by ERISA plans. Yet the *Travelers* decision does not imply that its result would have been any different if the taxes at issue had been imposed on the ERISA plan itself as part of the uniform application of a law of general applicability. The sole basis for the Second Circuit's decision that the HFA is preempted by ERISA in this case is that the state tax of general applicability, when applied to a plan-owned and operated facility, operates "directly" on the ERISA plan.[8/] *NYSA-ILA*, 74 F.3d at 30 ("[T]here is no third party between the plan and the tax imposed pursuant to the HFA"). There is no basis in law for this conclusion.

8/ It could be argued that the Court should have found that the HFA had only an indirect economic effect on the ERISA plan because the HFA is a direct tax on health care facilities and not on ERISA plans. *See* Walter Schuler, Note, *The ERISA Pre-Emption Narrows: Analysis of New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company and Its Impact on State Regulation of Health Care*, 40 St. Louis Univ. L.J. 783, 815-822 (1996). A health care facility owned by an ERISA plan is not a benefit plan. The state regulation does not affect the ERISA plan's administration or benefits.

In *Travelers*, this Court set forth a clear standard by which to evaluate whether surcharges on patient charges and on HMOs[9/] are preempted by ERISA:

> An indirect economic influence . . . does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself. . . . Nor does the indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the cost of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.

Travelers, 115 S.Ct at 1679. *See supra* note 1 regarding use of the word "indirect."

In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), this Court upheld the application of a general state garnishment statute to ERISA plan participants' benefits that were in the hands of the ERISA plan. Plan trustees were required to respond to a summons and deposit the demanded funds that were due to

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9/ One of the surcharges approved in *Travelers* was a tax on HMOs, which could run as high as 9% of the aggregate monthly charges paid by HMOs for their members' inpatient hospital care. There was no discussion in *Travelers* of whether the HMOs were owned and operated by ERISA plans.

the debtor. These were funds that the trustees were otherwise required to hold and pay out to participants and beneficiaries. "At the very least, petitioners contend, plans subjected to garnishment will incur substantial administrative burdens and costs." *Mackey*, 486 U.S. at 831.

Accepting that such administrative burdens and costs to the plan may be present, this Court nevertheless ruled that the general garnishment statute was not preempted by ERISA: "Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans, even when those mechanisms prevent plan participants from receiving their benefits." *Mackey*, 486 U.S. at 831-32. *See also Thiokol Corp. v. Roberts*, 76 F.3d 751 (6th Cir. 1996), *application for cert. filed*, 64 U.S.L.W. 3808 (U.S. May 23, 1996) (No. 95-1913) (Relying extensively on *Mackey*, 2.35% tax on businesses not preempted by ERISA, even though the tax base included employers' payments to employee benefit plans); *Retirement Fund Trust of the Plumbing v. Franchise Tax Bd.*, 909 F.2d 1266 (9th Cir. 1990) (California's general tax levy and withholding procedures not preempted as to ERISA plans); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir.) ("Connecticut's escheat law has both an economic and administrative impact on ERISA plans. Aetna will have to pay all unclaimed benefits to the State . . . [and] make administrative and accounting adjustments to comply with the law. . . . These *indirect* economic and administrative effects were not substantial enough, however, to persuade us that this is the type of law Congress intended to preempt."), *cert. denied*, 493 U.S. 811 (1989) (emphasis added); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987) (upheld a generally applicable 2% municipal tax on income, even when that income was contributed by employees to their ERISA benefit plans because it "affect[ed] Firestone employees in their capacity as employees, without regard to their status as participants in an ERISA plan.")

If ERISA plans do not want to pay the HFA directly, they can make a decision to offer their health benefits in a different way. "It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges." *Travelers*, 115 S.Ct at 1679. The HFA does not bind the plan to a particular choice, thereby regulating the plan. As demonstrated in *Mackey* and *Aetna Life*, the "direct" application of a state statute of general applicability to an ERISA plan, without affecting the primary operation and administrative function, such as eligibility for and amount of benefits, does not mean that the state statute is automatically preempted. *See Mackey*, 486 U.S. at 831-32; *Aetna Life*, 869 F.2d at 146-48. Particularly in this case, where the ERISA plan is functioning as a provider of medical services, even a "direct" effect on the ERISA plan should not be enough to preempt the state law because the impact is on the ERISA plan as a provider and not on its operations as an ERISA plan. *See Varity Corp.*, 116 S. Ct. at 1071 (recognizing that not all ERISA plan activities involve ERISA plan administration).

In *NYSA-ILA*, the ERISA plan decided to own and operate a medical clinic that was subject to the 0.6% HFA. If the ERISA plan had purchased insurance and paid the bill for its participant or beneficiary, it would have paid the HFA as part of patients' charges, a result clearly permissible under *Travelers*. Whether the ERISA plan pays the HFA in its function as a medical services provider or as an ERISA plan payer, the HFA does not force the ERISA plan to adopt a certain scheme of substantive coverage. The Second Circuit's decision in *NYSA-ILA* is inconsistent with Supreme Court precedent and should be reversed.

CONCLUSION

For the foregoing reasons, the decision of the Second Circuit Court of Appeals should be reversed.

Dated: November, 1996.

Respectfully submitted,

RICHARD BLUMENTHAL
Attorney General of Connecticut
Counsel of Record

PHYLLIS E. HYMAN
Assistant Attorney General
55 Elm Street
Hartford, CT 06106
Tel. No. (860)-566-2026

(Additional Counsel Listed on Inside Cover)

No. 95-1594

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

BARBARA A. DEBUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER JAMES P. MALIA, GERALD OWENS, and PETER VICKERS,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF *AMICI CURIAE* HEALTHCARE ASSOCIATION OF NEW YORK STATE AND AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

MARK THOMAS
HEALTHCARE ASSOCIATION OF NEW YORK STATE
74 North Pearl Street
Albany, NY 12207

FREDERIC J. ENTIN
JAMES A. HENDERSON
AMERICAN HOSPITAL ASSOCIATION
One North Franklin
Chicago, IL 60606

JEFFREY J. SHERRIN *
PHILIP ROSENBERG
SHERRIN & GLASEL
74 North Pearl Street
Albany, NY 12207-2710
(518) 465-1275

* *Counsel of Record*

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

No. 95-1594

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On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

BRIEF OF *AMICI CURIAE* HEALTHCARE ASSOCIATION OF NEW YORK STATE AND AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

Pursuant to Rule 37 of the Rules of this Court, the Healthcare Association of New York State ("HANYS") and the American Hospital Association ("AHA") respectfully submit this brief, as *amici curiae*, in support of Petitioners. Letter of consent by the parties have been filed with the Clerk of the Court.

It is the position of the *amici* that the preemption provision (section 514(a)) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a)(1994), does not apply with respect to a health care facility assessment (N.Y. PUB. HEALTH LAW § 2807-d (McKinney Supp. 1996)) (the "HFA") applied to a hospital established and operated by a self-insured employee benefit plan, where such assessment is imposed equally upon all hospitals in the state.

INTEREST OF AMICI CURIAE

Employee benefit plans covered under ERISA, 29 U.S.C. §§ 1001-1461 (1994), provide benefits to their members in a variety of ways. With respect to health care, for example, most plans provide coverage through commercial insurers or by self-insurance. The Respondent NYSA-ILA Medical and Clinical Services Fund (the "Fund") has adopted an approach that has become increasingly more common; it has established and operates medical clinics for its members, which provide care directly, rather than through insurance.[1]

In recent years, there have been dramatic changes in the structure of health care delivery systems throughout the country. Instead of being delivered by individual hospitals and other providers, health care today is being delivered through complex, multi-provider integrated delivery systems, often referred to as health care networks or

[1] Under New York State law, these clinics are "hospitals" that fall within the scope of article 28 of the New York Public Health Law. *See* N.Y. PUB. HEALTH LAW § 2801(1) (McKinney 1993).

alliances.[2] These integrated delivery systems may consist of several hospitals, as well as home care providers, physician networks, clinics, nursing homes and a full range of other health care providers that have allied themselves to compete more effectively in the managed care environment. These alliances also increasingly involve payers, such as health maintenance organizations ("HMOs"). Another recent phenomenon is that many employers are either contracting directly with provider networks or establishing their own clinics and networks, eliminating the role of the third-party payer and altering the traditional role of the community-based hospital.

Most states, and New York State in particular, have a long tradition of regulating health care delivery, cost and access. As two of the premier not-for-profit health care associations in the country, HANYS and AHA are vitally interested in the preservation of community-based health care delivery systems that assure comprehensive, readily-accessible, cost-effective and high-quality health care.[3] The decision of the Second Circuit Court of Appeals, however, will encourage the growth of hospitals and health care net-

[2] This is discussed in greater detail in Point I(B) below.

[3] HANYS is a not-for-profit, tax-exempt trade association that represents over 220 public and private not-for-profit acute care general hospitals across the State of New York, as well as nursing homes, home health agencies, and other entities. HANYS is the principal advocacy organization on behalf of New York's hospital industry and provides technical, administrative, legal and other services on behalf of its members.

Founded in 1898, the AHA is the primary national organization of hospitals in the United States. Its institutional members include approximately 70% of the nation's hospitals, and nearly 40,000 health care professionals hold individual memberships. The AHA's corporate mission is to lead, represent, and serve health care provider organizations that are accountable to the community and committed to health improvement. To fulfill this mission, the AHA regularly participates in the judicial and legislative arenas to address important issues concerning federal and state health care reform in general and hospital regulation in particular.

works that thrive, at the expense of the *amici's* members, from both an immunity to state regulation and an avoidance of the public responsibilities that HANYS's and AHA's members share. HANYS and AHA, therefore, consider the Court's decision here to be of paramount importance to the future of health care throughout the country.

SUMMARY OF ARGUMENT

On remand from this Court, *Chassin v. NYSA-ILA Med. & Clinical Servs. Fund*, 115 S. Ct. 1819 (1995), to reconsider its prior decision in this case, *NYSA-ILA Med. & Clinical Servs. Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994), in light of *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995) ("*Travelers*"), the Second Circuit held that ERISA bars a state from applying a general hospital gross receipts tax to hospitals operated by an ERISA plan on the ground that the tax "depletes the Fund's assets directly, and thus has an immediate impact on the operations of an ERISA plan." *NYSA-ILA Med. & Clinical Servs. Fund v. Axelrod*, 74 F.3d 28, 30 (2d Cir. 1996). The Second Circuit further held that *Travelers* has no effect upon its decision because *Travelers* dealt with an indirect economic impact, while *NYSA-ILA* deals with a direct economic impact.

The Second Circuit erred in holding that preemption under ERISA depended upon whether or not the state law's economic impact upon an ERISA plan was direct or indirect. The test it employed has no precedent in prior decisions of the Supreme Court, nor support in either congressional history or the language of ERISA. Instead, prior decisions of this Court have found no preemption where the law's impact was direct, and have repeatedly advised that preemption may be found even when a law's impact is indirect. The mere existence of an economic impact upon plans, whether direct or indirect, is insufficient for preemption. Rather, as stated in *Travelers*, the analysis must center upon the effect that the state law

has upon plan decisions, or plan administration, not simply whether it increases the costs of those decisions, directly or indirectly. The Second Circuit test would result in immunizing ERISA plan-owned health care facilities from any state regulation, a result Congress could not have intended.

The Second Circuit's test would also be virtually impossible to apply with any consistency or rationality, particularly because of changes in the health care delivery system that blur any distinction that once might have existed between direct and indirect effects. Finally, the state law at issue here does not relate to ERISA plans; it relates to hospitals. A plan's decision on how to provide health care coverage to its members may be protected from improper state interference, but once that decision is made and the plan decides to establish a hospital, that hospital must be subject to the same laws that apply to all hospitals. The operation of a hospital is not a plan function intended to be protected by ERISA from any state interference. A hospital is not an ERISA plan, nor is it a plan benefit; it is the manner by which the benefit is provided.

ARGUMENT

I. THE DIRECT/INDIRECT DICHOTOMY IS AN IMPROPER TEST FOR DETERMINING ERISA PREEMPTION

A. The Test Has No Precedent

This Court and lower courts have struggled since the inception of ERISA to define how far the broad preemptive scope of ERISA extends. *See Travelers*, 115 S. Ct. at 1675-78. This Court has emphasized that in any preemption question, ultimately, congressional intent is the touchstone. *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992). Attempting to define when a state law will be preempted, this Court has advised that a state law will "relate to" an ERISA plan "if it has a connection

with or reference to" a plan. *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-97 (1983). Under the "connection with" standard, this Court has cautioned that a state law may be preempted even if it is not specifically designed to affect ERISA plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990). Nevertheless, many laws of general application are not preempted where they have only a "tenuous, remote, or peripheral" connection with covered plans. *Shaw*, 463 U.S. at 100 n.21.

In *Travelers*, this Court recognized that prior attempts to construe the phrase "relate to" did not provide much help in drawing the preemption line, and that the phrases "relate to" and "connection with" cannot be interpreted too literally to define the measure of preemption. *Travelers*, 115 S. Ct. at 1676-77. Rather, the Court in *Travelers* stated that it must "look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 1677. This Court therefore conducted a comprehensive review of the purposes of the ERISA preemption provision and its legislative history, as well as congressional activity in the field of health care regulation, to determine the reach of ERISA preemption in connection with hospital rate regulation. *Id.* at 1677-82. Considering the surcharges at issue in *Travelers*, this Court distinguished laws with mere indirect economic impacts on plans from laws which mandate plan behavior. *Id.* at 1679.

What the Supreme Court has never said, and what Congress also did not say, is that the determinative test for ERISA preemption was to be merely whether the impact of the state law was direct or indirect. It would have been easy for Congress to have said so, and just as easy for this Court to have so pronounced. Congress, however, simply "did not write the statute that way," *Russello v. United States*, 464 U.S. 16, 23 (1983), and "[i]n a comprehensive regulatory scheme like ERISA, such omissions are

significant ones." *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 837 (1988). *See also BFP v. Resolution Trust Corp.*, 114 S. Ct. 1757, 1761 (1994). Instead, Congress used broad language, which this Court has held necessitates resort to traditional rules of preemption analysis to determine Congressional intent.

This Court has held that the preemption line is to be drawn based on the compulsory nature of the law or its effect upon plan administration, not on the directness of its impact. In *Mackey*, for instance, the Court found that ERISA did not preempt the direct application of a state garnishment law to benefits earned under an ERISA welfare plan. The Court explained that Congress simply never intended to block the application of run-of-the-mill state laws, such as garnishment statutes, to ERISA plans. If direct economic impact were the test, the result in *Mackey* should have been different.

The direct/indirect analysis employed by the Second Circuit must also be rejected because this Court has made clear that laws with indirect effects can also be preempted. In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981), it was stated:

> it is of no moment that New Jersey intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called 'pension regulation.' ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern.

See also Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139 (1990); *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129-30 (1992). In *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 704 (1985), this Court held that a mandated benefit law related to plans even though it only bore indirectly on such plans. And in *Travelers*, the decision concluded with the observation that laws with "acute, albeit indirect" economic effects might be preempted if they force plans

to behave in a certain manner. *Travelers*, 115 S. Ct. at 1683. If, as these cases teach, laws which bear indirectly upon ERISA plans may relate to such plans, then the determinative factor in *Travelers* could not have been simply the indirectness of the economic impact. Likewise, the question of preemption in *NYSA-ILA* cannot turn simply on whether the law affects plans directly or indirectly.[4]

B. The Test Is Impractical

A direct/indirect distinction not only has no support in prior decisions of this Court, but it would also prove to be too impractical to justify its adoption. The difficulty in separating direct from indirect effects is evident from the fact that the test was misapplied by the Second Circuit in *NYSA-ILA*. The medical centers that are the subject of this action and upon which the health facilities assessment was imposed were incorporated as not-for-profit corporations under special acts of the New York State Legislature. (Joint Appendix at 98). These medical centers are legal entities separate from the self-insured plan that established them. The assessment was not imposed upon the ERISA fund, but upon a separate hospital. The impact upon the ERISA fund, therefore, was not a function of the law itself, but rather of the relationship voluntarily established between the fund and the hospital. There did exist, therefore, the very "middleman" between the tax and the Fund that the Second Circuit stated to be absent.

[4] In other contexts as well, this Court has refused to accept a direct/indirect distinction as having any legal significance in determining congressional intent. Thus, in *Grove City College v. Bell*, 465 U.S. 555, 563-65 (1984), the Court rejected the argument that the characterization of federal assistance as direct or indirect would determine the application of a federal statute prohibiting sex discrimination in any education program or activity receiving Federal financial assistance. Instead, the Court in *Grove City* conducted a comprehensive review of congressional history and intent to discern the intended reach of the statute, much as this Court did in *Travelers*.

The line between direct and indirect impacts is far harder to discern than the Second Circuit perceived. As the health care system becomes more complex and payers and providers integrate, or assume multiple functions, the direct/indirect distinction will become more blurred.[5] State legislatures have begun to respond to this phenomenon. The Minnesota legislature, for example, has created integrated service networks that organize hospitals, physicians and insurance plans. *See* John E. Kralewski, et al., *The development of integrated service networks in Minnesota*, HEALTH CARE MGMT. REV., Fall 1995, at 42-56. New York recently enacted the Health Care Reform Act of 1996, which will create a new category of managed care licensure known as Integrated Delivery Systems. 1996 N.Y. Laws ch. 639, § 112-b (codified at N.Y. PUB. HEALTH LAW § 4408-a).

As *NYSA-ILA* shows, ERISA plans, employers and insurance companies are setting up their own health care

[5] In 1994, the Hospital Trustees of New York State reported that 45% of acute care facilities surveyed nationwide had formed an integrated delivery system in the preceding twelve months, and that another 25% indicated that they would enter into some form of integrated care in the coming six months. HOSPITAL TRUSTEES OF NEW YORK STATE, AN INTRODUCTION TO HEALTH CARE NETWORKS (1994). In New York City, hospital system and network formation has been so great that another 1994 survey conducted by the Greater New York Hospital Association reported that 82% of respondents were already in at least one network or system, more than 1 in 3 reported being in two or more networks, and almost half were part of a system in which they had equity or ownership in a managed care organization. *Id.* at 6. While there are many reasons for the formation of networks, "the most pressing is the clear indication that the healthcare reform discussions will result in some financing system that will reward the efficiencies suggested by streamlining and integrating care through networks." *Id.* at i. Just two years later, virtually all hospitals in New York State are now integrated with other hospitals, providers or payers in health care networks. *See also* PATRICIA A. BUTLER & ELIZABETH MITCHELL, HEALTH CARE PROVIDER NETWORKS; REGULATORY ISSUES FOR STATE POLICY MATTERS (National Academy for State Health Policy, Feb. 1996).

delivery systems. Recently reported examples include an occupational health clinic being built by Delta Air Lines in cooperation with its health insurer, CIGNA Health Care Inc., to be staffed by Emory University doctors. Robert Kazel, *Onsite clinic expected to cut Delta comp tab*, BUS. INS., Jan. 29, 1996, at 6. Deere & Co. has set up its own clinics and opened them to other companies. Louise Kertesz, *Employers, insurers center attention on primary care*, MOD. HEALTHCARE, June 19, 1995, at 136 (describing the "rush" of companies to build their own facilities). Quad/Graphics Inc. is planning to build its second onsite medical facility in five years, this time jointly with a Milwaukee-based system of 1,500 doctors, four hospitals and various other medical facilities. Robert Kazel, *Lowering costs onsite*, BUS. INS., October 23, 1995, at 2, 104.[6] It is also common for hospitals and unions to be establishing their own health maintenance organizations, or for insurance companies, HMOs, hospitals and other providers to form partnerships, sharing capital investments and financial risks.[7]

The implications of the Second Circuit decision in light of the revolutionary changes in health care are profound. If the impact of the HFA in *NYSA-ILA* was direct upon the plan because the plan owned the medical center, there should be no reason that the same result would not be

[6] Employers are also setting up their own child care centers (*see, e.g.*, Bruce Shutan, *Higher learning for K through* 3, EMPLOYEE BENEFIT NEWS, Feb. 1996, at 9; *How one employer implemented on-site child care*, Employee Benefits Mgmt. Directions (CCH) No. 109, July 11, 1995, at 1, 4; Robert N. Kazel, *New York Life sets up backup care center*, BUS. INS. Nov. 13, 1995, at 58), and legal services plans (*see, e.g.*, Leigh P. Perkins, *Solo Wins Prepaid Contract, Creates Instant Firm*, LAW. WKLY. USA, May 22, 1995, at 7-9), two of the other benefits that ERISA plans may provide in kind.

[7] *See* James C. Robinson, *Health Care Purchasing and Market Changes in California*, HEALTH AFFAIRS, WINTER 1995, at 117-30 (describing how previously autonomous organizations are consolidating into complex networks).

reached if the plan was a 75%, 50% or just 25% owner —the tax would still fall directly on the plan. A hospital, indeed an entire integrated delivery system, could immunize itself from state taxes and other costly regulation merely by transferring a minority ownership or operational interest to an ERISA plan. Similarly, it would appear that the 9% assessment in *Travelers* would have been preempted if the HMOs had been established by ERISA plans, or if the plans were part owners of the HMO.

The entanglement between plans and providers can occur in numerous other ways. If a hospital has a contract to provide care to a plan's members, and the plan agrees to share in the hospital's costs, would the HFA on the hospital be preempted as having a direct impact on the plan?[8] If not, how is that substantively different from the facts in *NYSA-ILA*? And if it is not substantively different, then a very easy solution has been found for providers to avoid state regulation—simply affiliate with an ERISA plan. If the NYSA-ILA hospitals establish a wholly-owned nursing home as a subsidiary, would the HFA applied against this nursing home be considered a direct or indirect assessment on the NYSA-ILA Fund?

The health care delivery and payer systems that are developing could not have been envisioned by Congress when it enacted ERISA in 1974. At that time, HMOs were in their infancy, managed care was a concept for the future, and integrated delivery systems and alliances were nonexistent. Health care delivery systems have been revolutionized since 1974, and the distinctions between employers, payers and providers are rapidly disappearing.

[8] The Fund here seeks immunity from the taxes not just on revenues attributable to services provided to longshore workers, retirees and dependents employed by NYSA employers, or even ILA members employed by non-longshore employers, but also to services provided to members of another union, the Port Police and Guards Union, pursuant simply to a contract between the PPGU's ERISA-covered plan and the Fund.

If a direct/indirect test could have had viability in 1974, it cannot now.

C. The Proper Analysis

The proper inquiry is not whether a state law that causes an economic impact upon plans does so directly or indirectly, but whether the law mandates an employee benefit plan's structure or administration. If it does, it does not matter whether it does so directly or indirectly. It is now well-established that Congress's purpose in enacting ERISA's preemption provision was to ensure that the field of employee benefit plans would be exclusively a federal concern. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). Specifically, Congress intended to eliminate the threat of conflicting and inconsistent state or local regulation of ERISA plans so that such plans could be structured and operated under a nationally uniform set of rules. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). *See also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (ERISA's preemption provision "was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law"); *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (ERISA ensures that plan providers would not have "to design their programs in an environment of differing state regulations [thereby] complicat[ing] the administration of nationwide plans.")

This Court, therefore, has distinguished state laws that impair an ERISA plan's ability to maintain a uniform structure and/or administration from other types of state laws that merely brush against such plans. In *Alessi, supra*, this Court ruled that ERISA preempted a New Jersey law that prohibited pension plans from offsetting workers' compensation benefits because it interfered with a plan's right to determine its pension benefits. Similarly, in *Greater Washington Bd. of Trade, supra*, and *Shaw, supra*, the Court found the respective state laws at issue

related to ERISA plans because they required plans to provide benefits to certain classes of individuals. And, in *FMC Corp., supra*, the Court held that a Pennsylvania anti-subrogation law could not prevent ERISA plans from being structured to seek reimbursement of certain medical benefits it pays to participants who recover from a third party.

On the other hand, in recognizing that ERISA plans are not free to operate in a world immune from all state laws, the Court in *Mackey, supra*, upheld the application of Georgia's general garnishment statute to benefits earned under an ERISA welfare plan. There, the Court reasoned that Congress never intended to exempt ERISA plans from a range of garden variety state laws that function without any particular regard to ERISA plans.

In *Travelers*, this Court ruled that ERISA did not preempt the imposition of three separate surcharges on state-regulated hospital rates. Although the surcharges were "passed on at least in part" to ERISA plans that provide certain health care benefits (*Travelers*, 115 S. Ct. at 1678), the Court explained that the economic nature of the impact was a "far cry" from the conflicting state directives that Congress was concerned about when it enacted ERISA. *Id.* at 1679. The surcharges simply affected the cost and type of benefits that a plan voluntarily decides to undertake.

In *Travelers*, therefore, this Court was not driven to the result by reason of the indirectness of the impact, but rather because the indirect influence "does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." *Id.* Similarly, the mandatory nature of a law, and not the directness of its impact, was the concern of the Court when it cautioned that:

> a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of

> insurers, and that such a state law might indeed be pre-empted under § 514.

Id. at 1683. But where the statute merely affects the cost of doing business, it is not preempted, whether it does so directly or indirectly.

II. HOSPITALS OPERATED BY ERISA PLANS ARE SUBJECT TO THE SAME LAWS THAT APPLY TO ALL OTHER HOSPITALS

The law at issue here is not a law that relates to ERISA plans; it is a law that relates to hospitals. ERISA plans were never intended to lead a "charmed existence." *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984). There is a difference between what a plan does as a plan and what it does as a hospital, landlord, or day care center. A plan's decision to self-insure, insure commercially or establish its own hospital and provide direct health care may be protected from state regulation, but once that decision is made, the plan is not immunized from regulation of the choice it makes. That point was established in *Travelers*. Once a plan decides to own or operate its own hospital, that hospital must be subject to the same regulation as all other hospitals, whether it be a gross receipts tax or a quality of care standard. Where such laws are applied evenly to all hospitals, they are laws of general application whose connection with plans is too "tenuous, remote, or peripheral" to be preempted.

A. The Direct/Indirect Test Would Displace General Health Care Regulation

Travelers made clear that:

> nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern[.]

Travelers, 115 S. Ct. at 1680. The Court warned that "it is fair to conclude that mandates for rate differentials would not be pre-empted unless other regulation with indirect effects on plan costs would be superseded as well." *Id.* at 1679. Thus, quality control and workplace regulations would fall because they would indirectly impact plan decisions. *Id.* Similarly, this Court in *Travelers* stressed that any other result would bar any state regulation of hospital costs, as well as the DRG system itself and any other interference in the hospital services market. *Id.* at 1681.

While *Travelers* made clear that ERISA's preemption provision should not be read too broadly so as to displace general health care regulation, it is just this displacement that will occur if the Second Circuit decision is upheld. Respondents' position, as reflected in the Second Circuit decision, creates an anomalous situation that could not represent Congress's intent. Unless Respondents contend that they are exempt from New York's laws of general application prohibiting the unlicensed corporate practice of medicine (*see* N.Y. EDUC. LAW § 6522 (McKinney 1985); N.Y. PUB. HEALTH LAW § 2801-a (McKinney 1993 & Supp. 1996)), they have accepted the right of the state to determine who or what entities may practice medicine in this state by obtaining the state's licensure under article 28 of New York's Public Health Law. These licensure laws obviously impact the medical centers directly because these laws control the fundamental question of whether or not the medical centers may be established. *See* N.Y. PUB. HEALTH LAW § 2801-a (McKinney 1993 & Supp. 1996). But if the Fund's medical centers are immune from a tax on hospitals, they should be equally immune from a state law requiring that those hospitals be licensed before they can dispense medical care. Certainly, a state law that controls whether the medical center can even exist relates more directly to the sponsoring plan than just a tax imposed on payments to the hospital for its services.

As with section 2801-a of the Public Health Law, the HFA applies to all hospitals regardless of whether the hospital is owned or operated by an ERISA plan.

These are both laws of general applicafion that operate in a traditional field of state regulation—health care. The HFA does not mandate plan structure or plan administration. It does not affect national uniformity. Like the surcharges in *Travelers* and so many other laws that relate to hospitals, the HFA merely increases the cost of doing business as a hospital. But in this regard, there is no difference between a tax imposed on gross revenues or laws requiring personnel standards, quality assurance, discharge planning, waste disposal or properly maintained equipment. They all increase the costs of doing business and are all imposed directly on hospitals.

Health care regulation is oftentimes undesirable for the provider. Regulation makes operations more difficult and more costly. But it is a traditional police power exercise to protect and promote the health of the populace. *See* N.Y. CONST. art. XVII, § 3. This Court determined in *Travelers* that Congress never intended ERISA to preempt that traditional state authority. If the HFA is preempted because it directly reduces the assets of the plan otherwise available to provide health care benefits, *NYSA-ILA Med. & Clinical Servs. Fund v. Axelrod*, 27 F.3d at 826, so will myriad other state laws be preempted that impose other or more expensive burdens upon the Fund's hospitals. Congress could not have intended that individual hospitals or integrated delivery systems be exempt from such regulation simply because they have a close relationship to an ERISA plan. The fact that the Fund here has voluntarily decided to operate a hospital does not change the ERISA-neutral character of the law. Instead, it is the plan which has changed its character from a plan to a health care provider.

B. Operating a Hospital Is Not a Plan Function or Benefit

Operating a hospital is different from administering a plan, which is what ERISA's preemption provision was intended to protect. In *Fort Halifax Packing Co. v. Coyne*,

482 U.S. 1, 9 (1987), the Court explained that ERISA's preemption provision was prompted by a recognition that a plan is the product of various complex administrative practices, including determining the eligibility of claimants, calculating benefit levels, making disbursements and maintaining appropriate records. By eliminating the threat of a patchwork scheme of state regulation over those administrative practices, the preemption provision was designed to ensure "that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Id.* at 11.

Not all activities performed by a plan constitute administrative practices protected by ERISA. ERISA plans may be tenants, parties to contracts and tortfeasors. Yet, "run-of-the-mill" state law causes of action such as for unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan are not preempted. *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 824, 833 (1988). Even though these every-day activities may, ultimately, support a plan's operations, laws regulating them are simply "too tenuous, remote and peripheral" to relate to a plan's ERISA functions. *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992).

In operating two hospitals, an area of traditional state regulation, the Fund performs a variety of activities ranging from credentialing professionals and maintaining equipment to disposing medical waste. Neither those activities nor the payment of taxes concern the administrative practices that this Court has identified as ERISA plan functions.

This distinction between a plan's ERISA and non-ERISA activities is also consistent with the recognition that, for purposes of the statute, a single entity may wear more than one hat. In *Varity Corp. v. Howe*, 116 S. Ct. 1065 (1996), this Court found that in making misrepre-

sentations about plan benefits, an employer was acting in its ERISA role as a plan fiduciary as opposed to its non-ERISA role as an employer, and was thus liable under ERISA for the harm the misrepresentations caused. This should be contrasted with the action of a plan in hiring and firing employees. The plan would be acting in its non-ERISA role as an employer, and not in its ERISA role as an employee benefits plan. The employment relationship would be subject to all state employment laws that do not interfere with plan structure or administration.

Another way of distinguishing between plan and non-plan activities is to differentiate between plans and benefits. ERISA preempts laws relating to plans, and not laws relating to benefits. Where, as here, benefits are provided in kind, the state is not precluded from regulating those benefits.

> The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and "plan," Congress' choice of language is significant in its preemption of only the latter.

Fort Halifax, 482 U.S. at 8.

Based on that difference, this Court in *Fort Halifax* upheld Maine's severance benefit law because the law's one-time payment obligation failed to constitute an ongoing administrative scheme necessary to have a plan. The Court explained that since the Maine law did not require an ERISA plan, the law did not create an impediment to ERISA's uniformity objective.[9] In *Travelers* this

[9] This result would not have been any different if an employer decided to comply with Maine's severance obligations through an ERISA plan. While an employer would have been free to structure its ERISA plan to satisfy its legal obligations, the state law did not mandate such a structure. *See also Shaw v. Delta Air Lines*, 463 U.S. at 108 ("while the State may not require an employer to alter its ERISA plan, it may force the employer to choose between providing disability benefits in a separately administered plan and including the state-mandated benefits in its ERISA plan.").

Court held that the surcharges were not preempted even though they increased the cost of providing health benefits because the higher costs did not preclude uniform administrative practices or the provision of a uniform interstate benefit package. *Travelers*, 115 S. Ct. at 1679. This is exactly the case with the HFA—it increases the cost of providing the benefit, but has no impact on the plan itself.[10]

Insofar as the HFA applies to the Fund, it does so in the Fund's role as the operator of a hospital, and not as an employee benefits plan. The fact that the Fund has elected to provide its benefits in the form of hospital services instead of insurance does not change this result. Rather, it only means that the Fund has decided to provide the benefit of health care coverage through direct provision of care, rather than through insurance. There are a multitude of costs and other factors, such as liability for malpractice, that enter into the decision of an ERISA plan whether to provide care directly or through insurance. The HFA is just one of those costs that affect the decision,

[10] The difference between plans and benefits also finds support in ERISA's legislative history. During the floor debates, Senator Javits, a sponsor of ERISA, explained that while a state may not regulate the "form and content" of an ERISA legal services plan, a state may impose ethical rules and guidelines, and institute disciplinary procedures with respect to the actual attorney services rendered under such a plan. 3 LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 4789 (1976). In addition, following his oft-cited remark that ERISA's preemption provision is the statute's "crowning achievement," Representative Dent, another sponsor of ERISA, explained that the provision was modeled after the preemption provision in the Health Maintenance Organization Act of 1973, (the "HMO Act"), Pub. L. No. 93-222, 87 Stat. 914 § 2 sec. 1311 (codified at 42 U.S.C. § 300e-10 (1994)). 3 LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 4670 (1976). That Act, however, regulates only the formation and operation of HMOs, and not the medical services and/or benefits they offer.

no different from how the surcharges in *Travelers* affected, but did not determine, the coverage decision.

CONCLUSION

The judgment of the United States Court of Appeals for the Second Circuit should be reversed.

Respectfully submitted,

MARK THOMAS
HEALTHCARE ASSOCIATION
OF NEW YORK STATE
74 North Pearl Street
Albany, NY 12207

FREDERIC J. ENTIN
JAMES A. HENDERSON
AMERICAN HOSPITAL
ASSOCIATION
One North Franklin
Chicago, IL 60606

JEFFREY J. SHERRIN *
PHILIP ROSENBERG
SHERRIN & GLASEL
74 North Pearl Street
Albany, NY 12207-2710
(518) 465-1275

* *Counsel of Record*

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

BARBARA A. DE BUONO, M.D., New York State Commissioner of Health, *et al.*,
Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

BRIEF OF THE NATIONAL GOVERNORS' ASSOCIATION, COUNCIL OF STATE GOVERNMENTS, NATIONAL CONFERENCE OF STATE LEGISLATURES, NATIONAL LEAGUE OF CITIES, U.S. CONFERENCE OF MAYORS, NATIONAL ASSOCIATION OF COUNTIES, AND INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

RICHARD RUDA
Chief Counsel
STATE AND LOCAL LEGAL CENTER
444 North Capitol Street, N.W.
Suite 345
Washington, D.C. 20001
(202) 434-4850
Counsel of Record for the
Amici Curiae

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QUESTION PRESENTED

Whether ERISA preempts New York State's gross receipts tax on health care providers.

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Statutes and Regulations

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Minn. Stat. Ann. § 295.581 4
N.H. Rev. Stat. Ann. § 84-A:5 4
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N.Y. Pub. Health Law § 2807-d 3
Vt. Stat. Ann. tit. 33, § 1956(b) 4
W.Va. Code § 11-27-32 4
29 U.S.C. § 1144(a) 5, 6, 9, 10
42 U.S.C. § 1396b(w) 2, 4

Other Authorities

National Association of State Budget Officers, *1995 State Expenditure Report* (1996) 2
Nina Martin, "ERISA: The Law That Ate Health Care Reform," 13 California Lawyer 40 (May 1993) 3

TABLE OF AUTHORITIES—Continued

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U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1996* (1996) 2, 3, 4
U.S. Department of Health and Human Services, National Center for Health Statistics, *Health, United States, 1995* (1996) 3
United States General Accounting Office, *Access to Health Care: States Respond to Growing Crisis* (U.S. GAO/HRD-92-70) 4

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INTEREST OF THE *AMICI CURIAE*

Amici, organizations whose members include state, county, and municipal governments and officials throughout the United States, have a compelling in-

terest in legal issues that affect state and local governments. The States, in a cooperative partnership with the Federal government, administer the Medicaid program to provide health care to the most needy and vulnerable. Providing this care, however, is extremely costly.

Although Medicaid is jointly funded by the States and the Federal government, according to HHS "[t]he State share of these expenditures now represents one of the largest and fastest growing components of most States' budgets." U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1996* 138 (1996). Indeed, between fiscal years 1990 and 1994, the States' Medicaid expenditures nearly doubled from $31.6 to $60.6 billion dollars. *Id.* at 400 (Table 109). Medicaid expenditures are the States' second largest spending category, having "grown from just over 10 percent of state spending in 1987 to 19.2 percent in 1995." National Association of State Budget Officers, *1995 State Expenditure Report*, Executive Summary at 3-4 (1996).

In response to the fiscal burden imposed by the rapid growth in Medicaid expenditures, New York and many other States adopted taxes on health care providers. These taxes, which are authorized by federal statute, *see* 42 U.S.C. § 1396b(w), provide a critical source of revenue to the States. An affirmance of the court of appeals' holding would not only deny States needed revenues whenever a provider is operated by an ERISA plan, it could also call into question the States' authority to collect provider taxes from self-insured ERISA plans that pay their beneficiaries' medical bills directly. *Cf. Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied*, 116 S. Ct. 1266 (1996). The latter is potentially a momentous concern for the States as "65 percent of the U.S. businesses that offer health benefits—and virtually all large corporations—are now self-insured." Nina Martin, "ERISA: The Law That Ate Health Care Reform," 13 California Lawyer 40, 43 (May 1993).

Because of the importance of this issue to *amici* and their members, this brief is submitted to assist the Court in its resolution of the case.[1]

STATEMENT

A. The Role Of State Health Care Provider Taxes

This case involves a challenge to New York's Health Facility Assessment, which is a six-tenths of one percent tax on the gross receipts of hospitals and other health care facilities providing diagnostic and treatment services under the supervision of a physician or dentist. N.Y. Pub. Health Law §§ 2801(1); 2807-d. New York enacted the tax to pay for the State's increasing health care costs and to avoid reductions in its funding under the Medicaid program.[2]

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[1] The parties have consented to the filing of this brief *amicus curiae*. Letters indicating their consent have been filed with the Clerk of the Court.

[2] New York's concerns are not unique. According to the Health Care Financing Administration, in 1994 state and local governments spent $117.2 billion on health care or 13.8 percent of their total budgets. U.S. Department of Health and Human Services, National Center for Health Statistics, *Health, United States, 1995* 239 (1996) (Table 114).

Medicaid spending comprises a substantial portion of state health care spending and state budgets. In fiscal year 1994, the States spent $60.6 billion on Medicaid. *Medicare and Medicaid Statistical Supplement, 1996*, at 400. This figure

New York is not alone in taxing health care providers. Federal law expressly authorizes the States to treat the revenues raised through such taxes as expenditures in obtaining Medicaid matching funds, *see* 42 U.S.C. § 1396b(w), and at least 18 States impose taxes similar to New York's HFA. These taxes provide a substantial portion of the States' share of the Medicaid program's cost, *see, e.g.*, Vt. Stat. Ann. tit. 33, § 1956(b); W.Va. Code § 11-27-32, raising approximately four billion dollars annually. In some States, provider taxes are also used to fund uncompensated care. *See, e.g.*, N.H. Rev. Stat. Ann. § 84-A:5; Mass. Ann. Laws ch. 118G, § 18. And Minnesota's health care provider tax is an integral component of the State's effort to expand health care coverage for uninsured persons who are not eligible for Medicaid. *See* Minn. Stat. Ann. §§ 295.58, 295.581; United States General Accounting Office, *Access To Health Care: States Respond to Growing Crisis* 47 (U.S. GAO/HRD-92-70); *Boyle v. Anderson*, 68 F.3d at 1097-98.

B. The Court Of Appeals' Decisions

In its initial decision, the court of appeals held that ERISA preempts New York's HFA. It rejected the State's argument that the tax is a "law of general application that affects ERISA plans only incidentally" and which "is no more directed at ERISA plans" than numerous other taxes and regulations. Pet. App. 11a. According to the court, New York's tax "relates to" an ERISA plan and is thus expressly

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represents nearly a doubling of state Medicaid expenditures from the fiscal year 1990 level of $31.6 billion. *Id.*

preempted by ERISA Section 514(a), 29 U.S.C. § 1144(a), because it

> depletes those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received. Both impacts will detrimentally affect the central mission and purpose of the Fund and hence cannot be characterized as remote or tenuous.

Pet. App. 12a.

In reconsidering its decision in light of *Travelers*,[3] the court of appeals concluded that *Travelers* was distinguishable and provided no ground upon which to disturb its earlier decision. Pet. App. 3a. According to the court of appeals, "[t]he statute at issue in *Travelers* did not impose surcharges on ERISA plans themselves, but on insurance carriers providing health insurance coverage to the plans and their beneficiaries." *Id.* It was thus distinguishable "because, unlike in *Travelers*, there is no third party between the plan and the tax imposed pursuant to the HFA. Rather, the statute at issue depletes the Fund's assets directly, and thus has an immediate impact on the operations of an ERISA plan." *Id.* at 3a-4a. Reasoning that "[n]othing in *Travelers* undermines our reliance on the HFA's direct economic impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of pre-emption," the court adhered to its original holding that ERISA expressly preempts the HFA. *Id.* at 4a.

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[3] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S.Ct. 1671 (1995).

SUMMARY OF ARGUMENT

1. New York's HFA is a classic exercise of the States' power to regulate the provision of health care and is not preempted by ERISA. It is a generally applicable tax that does not single out ERISA plans for discriminatory treatment. As such, it no more "relates to" ERISA plans than the generally applicable surcharges on hospital rates upheld by this Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S.Ct. 1671 (1995).

In *Travelers* the Court held that in determining the scope of ERISA preemption, it is necessary to "go beyond the unhelpful text" of ERISA Section 514(a) and "look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." 115 S.Ct. at 1677. This inquiry "'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.'" *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 19 (1987) (citation omitted). And in ERISA preemption analysis, as in preemption analysis generally, the Court must "work[] on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Travelers*, 115 S.Ct. at 1676 (citation omitted).

The Court explained in *Travelers* that Congress enacted Section 514(a) "'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law,'" *id.* at 1677 (citation omitted), and "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of em-

ployee benefit plans." *Id.* at 1677-78. Consequently, the Court has repeatedly held that ERISA preempts "state laws that mandate[] employee benefit structures or their administration." *Id.* at 1678.

New York's gross receipts tax on providers does no such thing. It does not single out ERISA plans for different treatment but instead applies to all medical facilities providing care under the supervision of a physician or dentist. It does not require plans to provide a benefit in New York which differs from the benefits which the plan provides to beneficiaries residing in other States. Nor does it burden plan administrators by requiring them to calculate benefit levels which differ from State to State. Because the HFA plainly does not interfere with any of the purposes which Congress sought to achieve in enacting ERISA, it is not preempted.

2. The court of appeals nonetheless held the HFA to be preempted because of its economic impact on ERISA plans. But as the Court explained in *Travelers*, if this were the test for ERISA preemption any state law that increases plan costs would be preempted. And "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." 115 S.Ct. at 1680.

On remand, the court of appeals sought to distinguish *Travelers* because the surcharges at issue in that case were imposed on insurance carriers and not directly on ERISA plans themselves. This reasoning ignores that the HFA's "connection" to an ERISA plan arises solely because the plan has chosen to provide medical care, a traditional area of state reg-

ulation and an activity engaged in by a wide range of entities. There is no more reason to think that ERISA preempts the HFA than that it preempts state licensing of medical practitioners or state laws that regulate the disposal of medical waste.

Moreover, the substantial surcharges at issue in *Travelers* had a far greater impact on the plans' ability to provide benefits to their members than the HFA, yet the Court did not hesitate to find that the surcharges were not preempted. *Travelers* unequivocally establishes that in enacting ERISA, Congress was not concerned with shielding ERISA plans from generally applicable state laws simply because those laws raise plans' costs.

ARGUMENT

ERISA DOES NOT PREEMPT NEW YORK'S GROSS RECEIPTS TAX ON HEALTH CARE PROVIDERS

The court of appeals erred in holding that ERISA preempts New York's Health Facility Assessment. The HFA is far removed from the concerns for the uniform administration of pension and welfare benefit plans which prompted Congress to enact ERISA. The HFA does not single out ERISA plans for discriminatory treatment. Rather, it is a generally applicable tax which no more "relates to" an ERISA plan than the generally applicable surcharges on medical bills upheld in *Travelers*. As such the HFA has "'only a tenuous, remote, or peripheral connection with covered plans,'" and is thus not preempted. *Travelers*, 115 S.Ct. at 1680 (quoting *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992)).

The court of appeals' holding inverts the traditional presumption against preemption of the States'

historic police powers and would provide ERISA plans with a wide ranging immunity from generally applicable state regulation, a result far removed from the concerns which prompted the enactment of ERISA. ERISA Section 514(a) does not condition preemption on whether a state law has a direct or indirect economic impact on a plan. *See Greater Washington Board of Trade*, 506 U.S. at 130 (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990)). The Court should therefore reverse the judgment below.

A. In Enacting Section 514(a), Congress Did Not Intend To Preempt State Gross Receipts Taxes On Health Care Providers

ERISA Section 514(a) expressly preempts "all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). While the Court has explained that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983), it has recently stated that Section 514(a)'s "expansive" text is not to be given a literal reading: "If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.'" *Travelers*, 115 S.Ct. at 1677 (quoting H. James, *Roderick Hudson* xli (New York ed., World's Classics 1980)). In a similar vein, the Court has explained that to say that "'[a] law "relates to" an employee benefit plan . . . if it has a connection with or reference to such a plan'" is of "no more help than . . . trying to construe 'relate to.'" *Id.* at 1677 (quoting *Shaw*, 463 U.S. at 96-97).

The Court has thus recognized that in determining whether ERISA preempts state law, it "must go beyond the unhelpful text [of Section 514(a)] and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* This inquiry, which the court of appeals did not conduct either in its initial decision or in its post-*Travelers* reconsideration, must, of course, " 'be guided by respect for the separate spheres of governmental authority preserved in our federalist system.' " *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 19 (1987) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981)).

This case involves a classic exercise of the States' traditional police powers. *See Hillsborough County v. Automated Medical Labs., Inc.*, 471 U.S. 707, 719 (1985) ("the regulation of health and safety matters is primarily, and historically, a matter of local concern") (citation omitted). In this case, as in every preemption case, the Court "work[s] on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.' " *Travelers*, 115 S.Ct. at 1676 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). This inquiry inescapably leads to the conclusion that ERISA does not preempt New York's generally applicable Health Facility Assessment.

As the Court has observed, Congress enacted Section 514(a) intending

> "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction."

Travelers, 115 S.Ct. 1677 (quoting *Ingersoll-Rand*, 498 U.S. at 142). The Court has further explained that "[t]he basic thrust of the pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 1677-78.

The Court has thus held that a New York law mandating that a plan provide certain benefits was preempted. *See Shaw*, 463 U.S. at 97. As the Court subsequently explained the *Shaw* decision, state

> mandates affecting coverage could have been honored only by varying the subjects of a plan's benefits whenever New York law might have applied, or by requiring every plan to provide all beneficiaries with a benefit demanded by New York law if New York law could have been said to require it for any one beneficiary.

Travelers, 115 S.Ct. at 1678.

The Court similarly held that ERISA preempted a Pennsylvania law prohibiting a plan from requiring a beneficiary to reimburse it in the event of recovery on a tort claim from a third party. *See FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990). The effect of the statute was to require plan administrators "to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States"

without similar antisubrogation legislation, thus "frustrat[ing] plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *Id.* Those Pennsylvania employees who won damages in tort actions "would, by virtue of the state law, in effect have been entitled to benefits in excess of what plan administrators intended to provide, and in excess of what the plan provided to employees in other States." *Travelers*, 115 S.Ct. at 1678.[4]

As the Court has explained, "[i]n each of these cases, ERISA pre-empted state laws that mandated employee benefit structures or their administration." *Id.* In each instance, the state laws would have resulted in plan administrators having to provide differing benefit levels depending upon a beneficiary's State. The state laws also interfered with the benefit levels agreed to by employers and employees through the collective bargaining process.

New York's tax on the gross receipts of health care providers raises no similar concerns. The tax does not single out ERISA plans for different treatment

[4] On similar reasoning the Court held that ERISA pre-empted a provision of New Jersey's Workers' Compensation Act which prohibited pension plans from offsetting an employee's retirement benefits by the amount of any workers' compensation award received by a retired worker. *Alessi*, 451 U.S. at 524-26. The state statute was deemed preempted because ERISA permitted pension plans to "integrat[e] . . . pension funds with other public income maintenance moneys for the purpose of calculating benefits" and the IRS has "approve[d] integration with the exact funds addressed by the New Jersey workers' compensation law." *Id.* at 524. Moreover, ERISA left the matter, "along with other pension calculation techniques, subject to the discretion of pension plan designers," *i.e.*, to the collective bargaining process. *Id.* at 525. The state statute thus intruded on the federal scheme.

but applies to all medical facilities providing care under the supervision of a physician or dentist; it is not dependent on the ownership status of the facility or on the source of payment for patient care. *See* N.Y. Pub. Health Law § 2801(1). The tax thus "makes no reference to, [and] indeed functions irrespectve of, the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139.

Most significantly, the tax does not require plans to provide a benefit in New York which differs from the benefits which the plan provides to beneficiaries residing in other States. *See Shaw*, 463 U.S. at 97. Nor does it burden plan administrators by requiring them to calculate benefit levels which differ from State to State. *See FMC Corp.*, 498 U.S. at 59-60. The tax simply does not interfere with any of the purposes which Congress sought to achieve in enacting ERISA. In short, the tax is a generally applicable statute which has " 'only a tenuous, remote, or peripheral connection with covered plans,' " and thus is not preempted. *Travelers*, 115 S.Ct. at 1680 (quoting *Greater Washington Bd. of Trade*, 506 U.S. at 130 n.1).

The court of appeals nonetheless held that the tax was preempted because it "depletes those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received." Pet. App. 12a. According to the court, "[b]oth impacts will detrimentally affect the central mission and purpose of the Fund and hence cannot be characterized as remote or tenuous." *Id.*

This view of the scope of ERISA preemption is so broad that it would require courts to hold preempted

virtually every generally applicable state law that increases the costs of an ERISA plan. It turns on its head the traditional presumption against preemption of the States' historic police powers, *see Travelers*, 115 S.Ct. at 1676, and ignores this Court's admonition that in construing Section 514(a), courts " 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.' " *Fort Halifax Packing*, 482 U.S. at 19 (quoting *Alessi*, 451 U.S. at 522).

Indeed, taken to its logical conclusion the court of appeals' holding would mandate the preemption of state laws requiring the licensing of physicians and nurses, regulating the disposal of medical waste, and setting the staffing levels and working conditions of medical support personnel, because such regulations undoubtedly increase the Fund's costs and thus either require it to reduce benefit levels or charge beneficiaries more.[5] But as the Court observed in *Travelers*, "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." 115 S.Ct. at 1680.

B. *Travelers* Is Not Distinguishable From This Case

On reconsideration, the court of appeals distinguished *Travelers* on the grounds that the surcharges on hospital bills paid by commercial insurers and

[5] Under the logic of the court of appeals, even a state minimum wage law would be preempted because to the extent it required the plan to pay its employees higher wages, it would deplete the plan's assets and "cause the [plan] to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received." Pet. App. 12a.

health maintenance organizations which were upheld therein were not imposed "on ERISA plans themselves, but on insurance carriers providing health insurance coverage to the plans and their beneficiaries." Pet. App. 3a. According to the court of appeals, "the present case [is] distinguish[able] . . . from *Travelers*, because, unlike in *Travelers*, there is no third party between the plan and the tax imposed pursuant to the HFA. Rather, the statute at issue depletes the Fund's assets directly, and thus has an immediate impact on the operations of an ERISA plan." *Id.* at 3a-4a. The court further asserted that "[n]othing in *Travelers* undermines our reliance on the HFA's direct economic impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of pre-emption." *Id.* at 4a.

The court of appeals' attempt to distinguish *Travelers* is unpersuasive. It ignores that the HFA's "connection" to the plan arises because the plan has chosen to engage in the provision of medical care, an activity which is a traditional concern of state regulation. It is no more credible to assert that ERISA preempts the State's authority to impose this tax than it is to argue that ERISA preempts the State's regulations regarding the licensing of the facility's physicians and the disposal of medical waste. Certainly, state laws requiring that the plan's medical personnel be licensed and mandating the method of medical waste disposal also "directly" impose increased costs on the plan but just as surely such laws are not preempted. The HFA, like the State's other regulations applicable to health care facilities, simply has too " 'tenuous, remote, or peripheral [a] connection with covered

plans' " to be within the ambit of ERISA preemption. *Travelers*, 115 S.Ct. at 1680 (quoting *Greater Washington Bd. of Trade*, 506 U.S. at 130 n.1).

It is thus not persuasive to distinguish *Travelers* on the ground that the surcharges upheld therein were indirect whereas the HFA is direct. *See* Pet. App. 3a-4a. Whatever the precise boundaries of ERISA preemption, it is clear that preemption is not dependent upon whether a state law has a direct or indirect impact on an ERISA plan, but rather on the substantive nature of the impact on the plan. *See, e.g., Travelers*, 115 S.Ct. at 1683; *Ingersoll-Rand*, 498 U.S. at 139. Indeed, it is quite illogical to condition preemption on such a distinction. The indirect surcharges upheld in *Travelers* are, after all, far more likely to reduce a plan's assets and its ability to provide benefit levels than the "direct" gross receipts tax of six tenths of one percent which New York has imposed here.

Travelers amply demonstrates that in enacting ERISA, Congress was not concerned with shielding ERISA plans from generally applicable state laws simply because they raise the plans' costs. And it is plainly not persuasive to suggest that a gross receipts tax of six-tenths of one percent has such an "acute" effect "as to force an ERISA plan to adopt a certain scheme of substantive coverage," thereby triggering preemption. *Travelers*, 115 S.Ct. at 1683; *see also Boyle v. Anderson*, 68 F.3d 1093, 1101-10 (8th Cir. 1995), *cert. denied*, 116 S.Ct. 1266 (1996) (rejecting ERISA challenge by self-insured ERISA plans to two percent provider tax). Because the HFA works no interference with Congress' purposes in enacting ERISA, the court of appeals erred in holding that it is preempted.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

RICHARD RUDA
Chief Counsel
STATE AND LOCAL LEGAL CENTER
444 North Capitol Street, N.W.
Suite 345
Washington, D.C. 20001
(202) 434-4850
Counsel of Record for the
Amici Curiae

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In The

Supreme Court of the United States

October Term, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health, DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS and PETER VICKERS,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF FOR THE SELF-INSURANCE INSTITUTE OF AMERICA, INC., AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

RONALD S. LONGHOFER
JOHN H. EGGERTSEN
HONIGMAN MILLER SCHWARTZ AND COHN
2290 First National Building
Detroit, MI 48226
(313) 256-7748

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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INTEREST OF AMICUS SELF-INSURANCE INSTITUTE OF AMERICA

The Self-Insurance Institute of America, Inc. ("SIIA") submits this *amicus curiae* brief with the consent of Petitioners and Respondents.[1]

SIIA is a non-profit corporation composed of over 1,200 members dedicated to the advancement and protection of (1) an employer's choice to purchase insurance or to self-fund employee benefit plans, (2) the industry that has developed to facilitate the self-funding alternative and (3) the principles of the Employee Retirement Income Security Act of 1974 ("ERISA"). It was the passage of ERISA in 1974 that freed employers from state laws requiring employers to buy commercial insurance to provide employee benefits.[2]

SIIA's membership includes employer/plan sponsors, service providers to plan sponsors and plans and other entities engaged in the administration of self-funded ERISA plans. Members of SIIA are directly involved in the health care coverage of tens of millions of Americans in every state of the Union. SIIA is the only association in the United States which represents firms, professionals and organizations which participate in a broad spectrum of self-funding for ERISA plans.

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[1] Original consent letters from Petitioners and Respondents have been lodged with the Court.

[2] This was accomplished by Congress' (i) declaring employee benefit plans to be separate legal entities (ERISA §502(d), 29 U.S.C. §1132(d)) and (ii) invalidating state laws that "relate to" these new, separate federal legal entities (ERISA §514(a), 29 U.S.C. §1144(a)).

Through SIIA, its members coordinate their views and provide practical information and recommendations to federal and state governments and the public on how the self-funding employee benefits system functions and the interplay between state and federal law, particularly ERISA and the freedom of choice that ERISA provides employers and the administrators of ERISA plans. This includes rendering assistance to courts in their deliberations on significant ERISA issues of broad concern to SIIA members and the public.[3]

SIIA has a particular interest in the ERISA pre-emption issues presented by the tax imposed by New York's 1990 Health Facility Assessment law[4] ("HFA Tax Law"). If the State of New York's efforts to directly tax ERISA plans are upheld by this Court, then the death knell may well have sounded for the principle that ERISA plans can operate free from state regulations.

Indeed, the State of New York, emboldened by its apparent victory in *New York State Conference and Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Company, et al.*,[5] (*"Travelers"*) has already enacted a new

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[3] In addition to filing numerous *amicus* briefs with the United States Supreme Court and many U.S. Courts of Appeals, SIIA has also been the associational plaintiff in a number of ERISA pre-emption cases involving self-funded ERISA plans. These cases include *SIIA v. Gallagher*, 11 EBC (BNA) 2162 (N.D. Fla. 1989), *aff'd without opinion*, 909 F.2d 1491 (11th Cir. 1990) and *SIIA v. Korioth*, 993 F.2d 479 (5th Cir. 1993).

[4] N.Y. Pub. Health Law §§2801(1), 2807-d(1)(a), 2807-d(2)(c) (McKinney 1993).

[5] 514 U.S. ___, 115 S. Ct. 1671 (1995).

taxing measure to be effective January 1, 1997.[6] The 1997 New York Hospital Tax Act is designed to raise as much as $2.6 billion dollars a year, largely from ERISA plans located throughout the United States, to be used (1) to provide health care to indigent New Yorkers, (2) to subsidize medical education in the State of New York and (3) to fund state health care initiatives by the State of New York.[7] This new New York Tax Act assesses a tax of between 8.18% and 57.27% on all ERISA plans that happen to pay a participant or beneficiaries' medical bill to a New York Hospital, even if the employer/plan sponsor and plan participants and beneficiaries all reside and do business outside the State of New York.[8] A plan participant's serious illness while vacationing in New York City can cost an ERISA plan operating in California tens of thousands of dollars in New York taxes that the ERISA plan did not know about, did not plan for, and did not prefund. ERISA pre-emption was enacted by Congress to preclude this very result.

It is vitally important to the future of ERISA plans (and the carrying out of the Congressional intent evidenced by Section 514(a) of ERISA, 29 U.S.C. §1144(a))

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[6] The New York Health Care Reform Act of 1996 (S 7954) (*adding* N.Y. Public Health Law §§2807-j, 2807-s and 2807-t) ("1997 NY Hospital Tax Act"). Exhibit A is an article from the 8/26/96 issue of the *New York Law Journal* that summarizes some of the salient points of this new state tax law.

[7] Exhibit A at page 3.

[8] The variation in the applicable tax rates depends upon whether or not representatives of the affected ERISA plans agree to pay the State of New York directly and consent to the jurisdiction of other New York courts. See Exhibit A.

that the holding in *Travelers* be limited to state laws having "[non]acute, albeit indirect, economic effects"[9] on the benefits and administrative schemes of ERISA plans. If *Travelers* is read to allow the direct taxation of ERISA plans, it will be but a short time before the regulation of ERISA plans will be balkanized into 50 fiefdoms, controlled by the taxing authorities of each of the several States and the "crowning achievement"[10] of ERISA, that 22 years ago gave employers and plan administrators freedom of choice, will be lost.

Unfortunately, *Travelers* has been read by Petitioners, the State of New York, and/or the Solicitor General of the United States (on behalf of the U.S. Department of Labor) as supporting the propositions that Congress did not intend for ERISA to pre-empt either state laws regulating traditional areas of local concern or state laws of general applicability. SIIA believes that neither Congressional intent nor this Court's holding in *Travelers* supports this proposition because it would strike at the heart of the Congressional purpose for ERISA pre-emption:

> "To avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 115 S. Ct. at 1677.

Accordingly, SIIA submits this *amicus curiae* Brief in support of Respondents.

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[9] *Travelers*, 115 S. Ct. at 1683.

[10] Remarks of Representative Dent, 120 Cong. Rec. 29197 (1974) (*quoted* in *Shaw v. Delta Airlines*, 463 U.S. 85, 99, 103 S. Ct. 2890 (1983)).

SUMMARY OF THE ARGUMENT

The holding of this Court in *Travelers* underscores that there cannot be any simple bright line test for ERISA pre-emption. The scope of pre-emption must be determined by the facts and circumstances of each case, keeping ERISA's objectives in mind, *i.e.*, fostering the provision of pension and welfare benefits by employers and employee organizations through the voluntary creation of employee benefit plans that are subject to a single uniform federal regulatory regime. *Travelers*, 115 S. Ct. at 1677.

Consistent with this objective, ERISA does not require a particular type of administrative scheme for ERISA welfare plans. Benefits may be provided by insurance, self-funding, or the provision of in-kind services, however the employer or the employee organization choose to have them provided. These choices are an essential part of the design and administrative scheme of each ERISA plan. The choice of how benefits are provided is part and parcel of an ERISA plan's basic structure. Petitioner's efforts to characterize ERISA plans as merely financial arrangements that are separate from the provision of benefits must be rejected.

No matter how designated, the HFA Tax Law is a direct "tax" by the State of New York on the assets of an ERISA plan. That ERISA plan is the combination of the NYSA-ILA Medical and Clinical Services Fund (the "Fund") and its medical clinics. By directly taxing the income from health care services provided at the medical clinics in New York (but not in New Jersey), the State of New York is taxing the assets of the ERISA plan simply

because the plan is providing benefits in New York and its assets are there. What happens if the plan's fiduciaries will not pay the tax because they refuse to ignore their duty to preserve plan assets or because the plan has insufficient cash to pay the tax?[11] Can the State of New York seize and close these clinics, thereby stopping the ERISA plan from providing any benefits? If the decision of the Second Circuit is not upheld this could be the consequence of allowing New York, or any other state, to directly tax the assets used by ERISA plans to provide benefits.

ARGUMENT

I. Introduction

This case is really about how this Court and the lower federal courts will interpret this Court's decision in *Travelers*. In *Travelers*, Justice Souter, on behalf of a unanimous Court, apparently articulated a new, additional threshold test to be utilized in determining whether or not ERISA pre-empts a state law in the context of a challenge by commercial insurers and HMO's. While ERISA was obviously implicated, no ERISA plan or employer/plan sponsor was a party in the case. This was because ERISA plans were only indirectly impacted. This is a critical fact in understanding the rationale of *Travelers*. The State of New York and the Solicitor General,

[11] A 57.27% tax, like that imposed by the 1997 NY Hospital Tax Act, could conceivably bankrupt many ERISA plans.

however, would equate a state-imposed increase in hospital bills that are paid by state-regulated and licensed risk bearers in the insurance industry with a direct tax on an ERISA plan, a creature of federal law.[12] Apparently, Petitioner and the Solicitor General believe that since this Court in *Travelers* found that a state law causing an indirect, non-acute economic impact on ERISA plans was not pre-empted, *Travelers* stands for the proposition that Congress intended to allow states to sieze the assets of ERISA plans, by whatever means, including direct taxation.

SIIA believes that Petitioners and Solicitor General grossly misread *Travelers*. The *Travelers'* decision is really a reflection of the difficulty in trying to draw bright lines in an area where individual factual inquiries are necessary. ERISA is an equitable law, emphasizing the need to tailor rights and remedies to individual cases.[13] The general desirability of having fixed principles of law must often give way in equity in order to provide individual justice.[14] This equitable nature of ERISA carries over into

[12] ERISA §502(d). *See also NGS American, Inc. v. Barnes*, 805 F. Supp. 462 (W.D. Tex. 1992), *aff'd*, 998 F.2d 296 (5th Cir. 1993) (plan is a separate legal entity with standing to sue state in declaratory judgment action to prevent imposition of fees and taxes).

[13] *See, generally, Firestone Tire and Rubber Co. v. Bruch* 49 U.S. 101, 109 S. Ct. 948 (1989). Indeed, this case arose as an equitable declaratory judgment action by the Respondent under the authority of ERISA §502(a), 29 U.S.C. §1132(a).

[14] "In equity, as nowhere else, courts eschew rigid absolutes and look to the practical realities and necessities inescapably involved in reconciling competing interests, notwithstanding that those interests have constitutional roots." *Lemon v. Kurtzman*, 411 U.S. 192, 201, 93 S. Ct. 1463 (1973). *See*

ERISA pre-emption litigation, where equitable and constitutional principles meet.[15]

The equitable nature of ERISA is in part explained by the fact that ERISA was passed to encourage the growth and development of a *voluntary*, employer-based, employee benefit system in the United States.[16] Congress realized that a major impediment to the growth of this voluntary system would be state laws.[17] The concept of ERISA pre-emption is not, therefore, the outgrowth of a turf battle between the federal and state governments over who will regulate ERISA plans. Rather, ERISA pre-emption was Congress' choice of what it believed was the

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also Hecht Co. v. Bowles, 321 U.S. 321, 329-330, 64 S. Ct. 587 (1944) ("The essence of equity jurisdiction has been the power of the Chancellor to do equity and to mold each decree to the necessities of the particular case. Flexibility rather than rigidity has distinguished it.")

[15] "[I]n constitutional adjudication as elsewhere, equitable remedies are a special blend of what is necessary, what is fair, and what is workable. 'Traditionally, equity has been characterized by a practical flexibility in shaping its remedies and by a facility for adjusting and reconciling public and private needs.' " *Lemon v. Kurtzman*, 411 U.S. at 200 (*quoting Brown v. Board of Education*, 349 U.S. 294, 300, 75 S. Ct. 757 (1955)).

[16] *Lockheed Corporation v. Spink*, ___ U.S. ___, 116 S. Ct. 1783, 1787 (1996).

[17] "It should be stressed that with the narrow exception specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." Comments of Senator Williams, 120 Cong. Rec. 29933 (1974) (*quoted in Pilot Life Insurance v. Dedeaux*, 481 U.S. 41, 46, 107 S. Ct. 1549 (1987)).

best method to ensure that there will continue to be employee benefit plans to regulate.

> "Faced with the difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines, an employer may decide to reduce benefits or simply not to pay them at all." *Fort Halifax Packing Co. v. Coyne*, 462 U.S. 1, 13, 107 S. Ct. 2211 (1987).

ERISA touches the lives and business of most Americans in many ways. The factual variations of each of these encounters makes it impossible to establish a single bright line test, or even several bright line tests, that can be articulated to describe the reach of ERISA pre-emption. There are more than one million ERISA regulated pension and welfare plans operating in every state of the Union that provide benefits to well over one hundred million Americans.[18] ERISA plans own over $1 *trillion* worth of stock in American businesses and almost as much in publicly traded bonds.[19] In 1993, ERISA health plans received and paid out more than $235 *billion* for medical bills of plan participants and beneficiaries.[20] These ERISA health plans, and their employer/plan sponsors, are also leading the way in the current dramatic

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[18] For example, in 1990, approximately 77 million Americans participated in 712,000 tax-qualified pension plans. (*See* Exhibit B). In that same year, 148.7 million Americans had employer-provided health care coverage. (*See* Exhibit C). (The exact number of ERISA medical plans is unknown, but it is safe to estimate the number to be in the many hundreds of thousands.)

[19] *See* Exhibit D.

[20] *See* Exhibit E.

restructuring of how health care in America is financed and delivered.

Being such important players in so many areas of American life, ERISA plans necessarily are involved in activities that usually are subject to state regulation, such as the business of risk taking; that is the business of commercial insurers and HMOs. Clearly, Congress did not intend that ERISA plans could totally ignore or be immune from appropriate state regulation, but Congress knew that there was no simple way of defining what state laws should apply to ERISA plans. Instead, Congress chose to set general guidelines for the operation of ERISA plans and their interplay with state law, and then left to the courts the responsibility of applying those principles in individual cases.

As a result of Congress' intentional decision to leave the area of ERISA pre-emption fluid, this Court has been called upon to rule on ERISA pre-emption almost every year since the enactment of ERISA (with three more cases, including this one, being argued this Term) and lower courts have had literally thousands of ERISA pre-emptions cases. Unless and until Congress chooses to either abandon its support of a voluntary employee benefit system in this country or to change the equitable nature of ERISA and ERISA pre-emption, many more cases will follow. That is simply the way ERISA was designed by Congress. Even if *Travelers* is read the way Petitioner or the Solicitor General suggests, ERISA pre-emption cases will abound. Congress, alone, can change that reality.

In SIIA's view, *Travelers* is simply another individualized ERISA pre-emption case. The principles and concepts laid out in *Travelers* will be useful in guiding courts in resolving future ERISA pre-emption cases, but it must be borne in mind that ERISA pre-emption decisions are necessarily highly fact specific. This is, of course, true of *Travelers* itself, which addressed ERISA pre-emption in the context of:

> "[a] New York statute require[ing] hospitals to collect surcharges from patients covered by a commercial insurer . . . whose commercial insurance coverage is purchased by employee health care plans governed by ERISA . . . ."[21]

Travelers did not even involve a surcharge or tax on commercial insurers, much less on ERISA plans. The issue addressed by Justice Souter was whether these new *indirect* costs (that were passed on from patient to commercial insurer to ERISA plan) amounted to the regulation of an ERISA plan's benefit design or choice of administrative scheme.[22]

Rather than trying to shoe-horn this fact pattern into principles established by previous decisions of the Court based on completely different fact patterns,[23] Justice Souter observed that this Court's jurisprudence interpreting

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[21] *Travelers*, 115 S. Ct. at 1673-74.

[22] *Id.* at 1683.

[23] Such as State mandated benefits (*Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 705 S. Ct. 2380 (1988)); State wrongful discharge laws (*Ingersoll-Rand v. McClendon*, 458 U.S. 133, 111 S. Ct. 478 (1990)); State sex discrimination laws (*Shaw*), *supra* and State workers compensation laws (*District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 113 S. Ct. 580 (1992)).

the phrase "relate to" proved insufficient for this fact pattern and that therefore the Court had to:

> "[L]ook instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 115 S. Ct. at 1677.

SIIA urges this Court and lower courts to read *Travelers* together with all other previous binding ERISA pre-emption decisions, in light of their inherent factual limitations. The desire to create bright lines by citing *Travelers* (or any other decision of this Court), for general, all inclusive principles in order to bring certainty to this area must be resisted. *Travelers*, and the previous ERISA pre-emption decisions, give guidance but do not dictate this Court's results, except in those cases which are factually indistinguishable from the cited authority.

SIIA therefore believes that it is not helpful or appropriate to speculate on what the principles of *Travelers* may mean in a variety of fact patterns not before the Court. Listing a "parade of horribles" regarding state licensure laws or child care centers, as state of New York and the Solicitor General do in their briefs, simply clouds the issues. Once ERISA pre-emption becomes a relevant inquiry with respect to those fact patterns, appropriate decisions will be made. For the moment, it is enough to review the HFA Tax Law as a state law that attempted to tax the assets and operations of an ERISA plan.

II. Direct Taxation or Regulation of an ERISA Plan by a State is Pre-empted By ERISA Unless the State Law is Limited to Plan Activities Unrelated to its Administration or Benefits

A. There is No Single Type of Administrative Scheme for ERISA Plans

While it may be true that most ERISA plans simply pay third-parties to provide employee benefits, it is clear that the definition of employee benefit plan under ERISA is not so limited. As previously noted, Congress chose to lay out ERISA's principles in broad, sometimes vague terms, in order to allow employer flexibility in the provision of employee benefits. This principle is most graphically illustrated by looking at ERISA's definition of "employee benefit plan," the cornerstone of all of ERISA.

In an effort to get its arms around the wide variety of benefit programs in the private sector, Congress chose to look at the benefits provided rather than the method used to provide those benefits. For example, the definition of an "employee welfare benefit plan" found in ERISA §3(1),[24] 29 U.S.C. §1002(1), covers any mechanism utilized

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[24] ERISA Section 3(1) provides that the terms "employee welfare benefit plan" and "welfare plan" means *"any plan, fund, or program* which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was *established or is maintained for the purpose of providing* for its participants or their beneficiaries, *through the purchase of insurance or otherwise*, (A) medical, surgical, or hospital care *benefits*, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or

by employers (or unions) to provide employees and their families with medical, disability, death and several other types of welfare benefits. There is no administrative scheme or methodology required in order to be an ERISA "employee welfare benefit plan." Quite the contrary, Congress intended to encompass any and all methodologies used to provide employees with the types of benefits within the definition of employee welfare benefit plan so that the protections of ERISA could be enjoyed by as many employees as possible.[25] All agreements and methodologies essential to the provision of welfare benefits are, taken together, the ERISA "welfare benefit plan."[26]

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other training programs, or day care centers, scholarship funds, or pre-paid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 U.S.C. Section 186(c)] (other than pensions or retirement or death, and insurance to provide such pensions) (*emphasis added*)."

[25] The wisdom of this approach was illustrated in *Gilbert v. Burlington Industries, Inc.*, 765 F.2d 320 (2nd Cir. 1985), *summarily aff'd*, 477 U.S. 91, 106 S. Ct. 3267 (1986). In *Gilbert*, the employer claimed that its severance pay program was not an ERISA plan because the employer did not want to be covered by ERISA. The employer never (a) published or filed an annual report or a final financial statement, (b) distributed a summary plan description or a statement of material modifications, (c) designated a fiduciary to administer the plan, or (d) informed employees of their rights under ERISA or under the plan. Furthermore, there was no procedure for claims or appeals of a denied claims. Finally, there were no assets segregated to pay severance because all payments were being made from the employer's general assets. The Second Circuit had no problem finding that Congress intended that this kind of arrangement was an ERISA plan.

[26] The definition of "employee pension benefit plan" found in ERISA §3(2), 29 U.S.C. §1002(2) similarly looks at the benefits

In this case, the "employee welfare benefit plan" involved is not just the Respondent Fund. Here, the employee welfare benefit plan is the Fund and the New York and New Jersey medical clinics run by the Fund (which are essential parts of the program by which medical benefits are provided). Both the fund and the clinics are necessary to provide participants and beneficiaries with their medical benefits and therefore both are integral parts of the "employee welfare benefit plan" that is subject to ERISA.

Therefore, the administration of the Fund and the operation of the New York and New Jersey medical clinics together constitute the administration of an ERISA plan.

B. The HFA Tax Law "Relates to" the Administration of this ERISA Plan

As the Second Circuit found, "the Fund provides these health care benefits through three medical centers that it owns and operates, two in New York and one in New Jersey."[27] The administrative scheme for providing benefits under this ERISA plan, therefore, includes the funding and operation of the medical centers. The tax imposed by the HFA Tax Law on the medical centers (and any penalties for failing to pay that tax) are provisions of

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provided (retirement income or deferral of income to termination of covered employment or beyond) rather than the way in which retirement benefits are provided to define "employee pension benefit plan."

[27] *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 27 F.3d 823, 825 (2nd Cir. 1994). (*"Axelrod I"*).

a state law that directly impacts this scheme of plan administration.

The State of New York is simply wrong, therefore, in its characterization of the benefits provided by the ERISA plan involved in this case. Perhaps based upon its traditional role of regulating the business of insurance, New York in its brief erroneously states:

> "[T]he state may regulate ERISA plan-owned hospitals because the ownership of the hospital is not part of the plan's benefit structure. The benefit structure by the NYSA plan in this case is health care coverage. The plan assumes the obligation for the payment of health care services that are provided to plan participants. This benefit, health care coverage, is the same regardless of whether a plan purchases it by self-insuring, purchasing HMO memberships, purchasing traditional indemnity insurance, or providing services in kind." Petitioner's Brief at 21-22.

To the contrary the *employee benefits are the health care services provided at the medical clinics in New York and New Jersey*, not "coverage" or payments to third parties for health care services rendered. The ownership of the medical centers is not "incidental to the plan's benefit structure,"[28] the *ownership of those centers is the way that health benefits are provided.*

To characterize this ERISA plan as being no different, for ERISA pre-emption purposes, than ERISA plans that pay third parties for medical services is exactly the type

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[28] Petitioner's Brief at 22.

of gamesmanship that Congress feared when it included the so-called "deemer clause" in ERISA.[29] Even if one ignores the fact that the New York and New Jersey medical centers only exist because of the direct benefits provided by this ERISA plan and limits the inquiry to the payments received by the medical centers from other ERISA plans and their participants, the same impermissible impact on this ERISA plan's benefits and administrative scheme occurs.[30]

In the words of the Second Circuit in *Axelrod I*,

> "Restructure[ing] its finances so that the funds formerly remitted by plan participants and employers directly to the medical centers would be remitted to the Fund which would subsequently transfer them to the centers . . . would alter the Fund's established method of administration and would require it to implement procedures for its New York facilities to differ from

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[29] ERISA §514(b)(2)(B), 29 U.S.C. §1144(b)(2)(B). The "deemer clause" protects ERISA plans from states trying to extend the "savings clause" of §514(b)(2)(A) to ERISA plans by deeming them "to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." The same principle equally applies to New York's attempt to "deem" this ERISA plan's benefits to be "health care coverage" (an insurance law concept), rather than the direct provision of benefits, in order to avoid ERISA pre-emption.

[30] It is not clear whether the State of New York is willing to so limit the inquiry. The Solicitor General seems to assume that is the case. *See Amicus* Brief United States at 4 n. 3.

those of its New Jersey facility." *Axelrod I*, 27 F.3d at 827-28.

It is hard to imagine a more blatant example of an "administrative and financial burden" that frustrates the achievement of the "nationally uniform administration of employee benefit plans." *Travelers*, 115 S. Ct. at 1697.

III. Petitioner and *Amicus* United States Misread *Travelers*

As noted above, both the State of New York and the Solicitor General have asserted in their briefs that *Travelers* should be read to support the proposition that Congress intended state laws regulating traditional areas of local concern and state laws of general applicability to be exempt from ERISA pre-emption.

The Solicitor General argues that the case law interpreting ERISA has created three categories of state law which are pre-empted: (i) areas where ERISA provides law or remedies, (ii) state laws imposing rules on ERISA plans regarding their structure and administration, and (iii) state laws dictating what benefits should be provided. *Amicus* Brief United States at 9-10.

> "There is no basis for extending pre-emption under §514(a) to state laws of general applicability that do not fall into any of the above categories." *Id.* at 10.

Any state law of general applicability outside of these three categories presumptively does not "relate to" an ERISA plan and is not, therefore, pre-empted.

Fortunately, the scheme established by Congress does not share the same presumptions. First, all state laws which "relate to" ERISA plans are pre-empted, whether laws of general applicability or not. Then Congress set forth certain exemptions to ERISA pre-emption for traditional areas of state regulation, *e.g.*, insurance, banking and security laws, state criminal laws, and state domestic relations laws. Congress specifically noted that tax laws relating to ERISA plans were pre-empted.[31] Congress set forth no rules on when state laws "relate to" ERISA plans, but left that to the courts to determine case by case.

Petitioner, *citing Travelers*, would do even more violence to the longstanding principles of ERISA pre-emption.

> "In *Travelers*, 115 S. Ct. at 1679, this Court held that state laws of general applicability in areas of traditional state regulation do not relate to plans, even if they have an economic impact upon plan choices, so long as they do not dictate or restrict plan benefit structure or plan administration."[32]

And again later on in Petitioner's brief:

> "In both *Travelers* and in this case, the state law has an effect on ERISA plans only because, and to the extent that, plans have chosen to engage

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[31] ERISA §514(b)(5)(B)(i), 29 U.S.C. §1144(b)(5)(B)(i).

[32] Petitioner's Brief at 8.

> in activity that is covered by the generally applicable state law. That incidental effect is too 'tenuous, remote, or peripheral' to warrant a finding that the law 'relates to' ERISA plans."[33]

Both Petitioner and the Solicitor General sought to base their revisionist readings of ERISA pre-emption jurisprudence on this Court's references to "fields of traditional state regulation"[34] and "laws of general applicability."[35] None of these general references in *Travelers* justify the reading of Petitioner or *Amicus* United States, a reading which amounts to a total reversal of 22 years of ERISA pre-emption jurisprudence.

Travelers' reference to "fields of traditional state regulation" was for the purpose of noting the judicial assumption against invalidating a state's exercise of its historic police powers unless Congress clearly manifested that intent. In ERISA §§514(a) and (b) Congress did manifest that intent.

Congressional concern with respecting areas of law traditionally regulated by the states is the reason for most of ERISA §514(b)(2), 29 U.S.C. §1144(b)(2). Such areas of traditional state regulation as (a) state regulation of the businesses of insurance, banking and securities are all carved out from ERISA's broad pre-emption scheme (b) generally applicable state criminal law, and (c) domestic relations law. To now suggest that Congress forgot to

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[33] Petitioner's Brief at 26.

[34] *Travelers*, 115 S. Ct. at 1676.

[35] *Id.* at 1680 (*quoting Greater Washington Bd. of Trade*, 113 S. Ct. at 583 n. 1).

exclude from ERISA pre-emption other areas of traditional state regulation is absurd.[36] Congress clearly has understood that such laws must be specifically listed in ERISA §514(b) to be saved from pre-emption under ERISA §514(a).

The best example of Congress' understanding of how ERISA §§514(a) and (b) fit together is in the area of domestic relations law, as much, if not more, "an area of traditional state regulation" as is health care delivery. Nonetheless, Congress found it necessary to amend

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[36] The *Amicus* Brief of the United States, at n. 16, makes a half-hearted effort to fill this hole in its argument. (Petitioner does not try.) The Solicitor General contends that some traditional areas of state regulation and taxation (*e.g.*, social welfare activities) do not "relate to" ERISA plans because ERISA does not "provide law" on those subjects. Therefore, says the Solicitor General, these laws need no saving from pre-emption by ERISA §514(b). The Solicitor General does not explain why other areas of traditional state regulation and taxation, such as insurance, banking and securities laws (for which ERISA also provides no law) need to be saved from pre-emption by ERISA §514(b) if these areas of law do not "relate to" ERISA plans. The short answer is, of course, that test of ERISA pre-emption is not and never has been whether ERISA "provides law" in a particular area of concern or regulation. Moreover, the Solicitor General ignores a basic principle of statutory construction, *i.e.*, where "Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of a contrary legislative intent." *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-17, 100 S. Ct. 1905 (1980). The legislative intent under ERISA is for expansive, not restrictive, pre-emption of state laws. *See Pilot Life*, 481 U.S. at 46 ("[T]he express pre-emption provisions are deliberately expansive and designed to establish [benefit] plan regulation as exclusively a federal concern").

ERISA §514(b) twice[37] to specifically exempt from ERISA pre-emption under §514(a) state laws dealing with Qualified Domestic Relations Orders and Qualified Medical Child Support Orders. Even these statutory exemptions from ERISA pre-emption do not protect all state domestic relation orders. Domestic relations court orders which fail to be "qualified," (as that term is defined by Congress and not by state legislatures or courts) are not protected by ERISA §514(b)(7) from ERISA pre-emption.

The reference in *Travelers* to "laws of general applicability" upon which Petitioner relies involved a quote from *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 n. 1, where this Court sought to explain the "too tenuous, remote, peripheral connection" test first enunciated in *Shaw*, 463 U.S. at 100 n. 21. The reference never sought to exempt such state laws from ERISA pre-emption generally, as Petitioner now contends. The Court's discussion in *Greater Washington Bd. of Trade*, merely underscores the difficulty of limning the scope of ERISA pre-emption with respect to such state laws.

The holding in *Travelers* is most succinctly described in that decision's penultimate paragraph. A state law that indirectly increases the health insurance premiums ERISA plans must pay is not pre-empted because it does not directly or indirectly force ERISA plans to change benefits or restrict their choice of insurers. No amount of selective citation can transform this straight forward

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[37] First, in the Retirement Equity Act of 1984, P.L. 98-397, to allow for QDROs, and next in the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, sanctioning QMSCOs.

holding into support for the radical proposition described in the briefs by Petitioner and the Solicitor General.

CONCLUSION

The broad pre-emption provision in ERISA was expressly designed by Congress to displace state laws, primarily because of the increasingly interstate nature of employee benefit plans and the often conflicting state standards applicable to such plans. To limit the breadth of the pre-emption provision in connection with state tax laws, such as the one at issue here, that directly impede the ability of ERISA plans to provide benefits would violate Congress' clear mandate to free voluntary ERISA plans from the reach of intrusive and conflicting state law. The failure to uphold the Second Circuit's decision would open the door for state legislatures throughout the United States, in flawed reliance on a mythical "traditional local law" or "law of general application" standards, to enact statutes which directly tax ERISA plans. Such a development would threaten the very viability of

ERISA plans and self-insurance as an attractive alternative for providing health benefits to millions of employees and their families.

Respectfully submitted,

Dated: Detroit, Michigan
December 30, 1996

RONALD S. LONGHOFER, Esq.*
JOHN H. EGGERTSEN, Esq.
HONIGMAN MILLER SCHWARTZ AND COHN
2290 First National Building
Detroit, MI 48226
(313) 256-7800

Counsel to Amicus The Self-Insurance Institute of America, Inc.

EXHIBIT A

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SECTION: HEALTH CARE CAN; Pg. 7

LENGTH: 2669 words

HEADLINE: N.Y. Health Care Reform Act of 1996; Rate Regulation Abandoned

BYLINE: MARK THOMAS; Mark Thomas is general counsel of the Healthcare Association of New York State (HANYS) in Albany.

BODY:

THE PASSAGE of the New York Health Care reform Act of 1995, as embodied in Assembly Bill 11330, marks a major shift in New York State health care policy.

Since 1983, New York State hospitals have been operating under a rate-regulated systems – the New York Prospective Hospital Reimbursement Methodology (NYPHRM), a reimbursement system under which the state determined all non-Medicare payments for hospital inpatient care. The NYPHRM system extended state control over hospital financing, continued stringent regulatory control, and established a mechanism – the bad debt/charity care pools – to partially compensate hospitals for caring for individuals with no insurance or ability to pay.

Throughout its history, the focus of the NYPHRM legislation has been broadened beyond hospital inpatient financing and has addressed a variety of other issues

from insurance for children to excess medical malpractice insurance for physicians. The NYPHRM approach, however, has become increasingly out of step with the lightning-speed transformation of the health care delivery system.

In recognition of the changing health care environment, the preamble to the Reform Act states in part: "New York York [sic] should move toward a system of negotiated rates for all non-Medicare payers; the State should maintain a significant role in assuring quality and access to care; and the State should continue to provide for the financing of public policy objectives unlikely to be addressed through market forces."

In order to achieve these purposes and to allow for a transition period, the Act extends NYPHRM until Dec. 31, 1996, and replaces it with a market-driven, hospital financing system accompanied by a cornucopia of health-related initiatives. In addition, it provides a unique opportunity for providers seeking to assume risk and contract directly – without an insurance intermediary – with patient groups by authorizing the operation of integrated delivery systems.

Beginning Jan. 1, 1997, payments for hospital impatient [sic] care will change dramatically with hospitals, Blue Cross plans, commercial insurance carriers, health maintenance organization (HMOs), and self-insured plans authorized to negotiate inpatient prices. Medicaid free [sic]-for-service payments will continue to be set by the state through 1999 and will not be negotiated or selectively contracted. Workers' compensation/no-fault

rates will be set at the Medicaid fee-for-service rates, and these carriers will not be allowed to negotiate payments.

Under the state-controlled NYPHRM system, many so-called public goods, such as the provision of charity care, the extensive graduate medical education infrastructure and various health insurance programs, were financed by mandatory rates and rate surcharges paid by insurers and other payers.

Reflecting the fear that financing for these societal goods would be abandoned under a purely negotiated price system, the Reform Act establishes three pools – indigent care, health care initiatives and graduate medical education (GME) – to fund these and other public goods, with total annual funding of these pools expected to reach approximately $ 2.6 billion. While these pools are a new creation, they are funded by the same sources as under NYPHRM – the entities, public and private, that pay for hospital and health care.

Recognizing that hospitals will continue to care for individuals who have no insurance or who cannot pay for their health care services, the Reform Act creates a new mechanism – the indigent care pool – for financing and distributing uncompensated care funds for the years 1997 through 1999. The indigent care pool will provide approximately $ 738 million to hospitals and $ 48 million to diagnostic and treatment centers for uncompensated care.

Each third-party payer except Medicare, Medicaid and workers' compensation/no-fault carriers will be allowed to make payments to the indigent care pool using a formula based on the payer's prior expenditures for

hospital inpatient and outpatient care, services provided by diagnostic and treatment centers that provide a comprehensive range of primary health care services or ambulatory surgical services, and freestanding clinical laboratories. Those third-party payers electing to make payments directly to the pool on a periodic basis would pay 8.18 percent of its prior annual cost of these services.

A payer may alternatively elect to pay an indigent care surcharge on an "encounter" basis when patient services are received. The encounter surcharge would equal the assessment described above plus an additional 24 percent. Under this scheme, the provider remits the entire surcharge to the pool, but is able to retain 2 percent to cover the administrative costs of collecting the encounter payments. The encounter assessment would apply to the same range of services and providers, i.e., hospitals, certain diagnostic and treatment centers and free-standing laboratories.

It is anticipated that the large majority of third-party payers, including self-insured plans, will opt to make periodic payments directly to the pool to avoid the 24 percent additional charge imposed under the "encounter" approach.

Since Medicare is a federal program, it will not pay any surcharge while Medicaid and workers' compensation/no fault payers will pay a flat assessment that is added to each hospital bill; the election option is not available.

Funds generated by these assessments would be primarily distributed to hospitals across the state based on a statutory "need" formula. Those with greater amounts of

charity care and bad debts, and publicly operated hospitals, would have a greater percentage of their need met under the formula. Also eligible for indigent care payments are comprehensive diagnostic and treatment centers that are voluntary, non-profit or publicly sponsored, provide a comprehensive range of primary health care services, and can demonstrate losses from a disproportionate share of uncompensated care.

Graduate medical education (GME) costs, i.e., those associated with training interns and residents, will be funded for non-Medicare payers at $ 1.385 billion per year over the three year period, 1997-1999, or approximately 75 percent of the current non-Medicare funding level of $ 1.85 billion.

Medicaid and workers' compensation/no-fault insurers will continue to pay full GME costs as part of the state-set fee-for-service payments. In the case of Medicaid beneficiaries enrolled in managed care plans, separate payment of GME, on a per discharge basis, will be made. Total Medicaid GME payment is projected to be $ 791 million in 1997, and workers' compensation/no-fault GME payments are projected to be $ 50 million.

Third-party payers – Blue Cross, commercial insurers HMOs for their non-Medicaid/non-Medicare business, and self-insured funds – will contribute to a GME pool, to be known as the "professional education pool," which is to be funded at $ 545 million per year for the three-year period. Funds from this pool are allocated on a regional basis, in order that amounts collected from payers in a region will be distributed to teaching programs in that same region.

As is the case with the indigent care pool, third-party payers will have a choice of payment options. The basis for the GME funding surcharge, however, is fundamentally different. A payer may elect to make periodic payments directly into the GME pool using a formula not based on prior health expenditures but rather on the payer's number of "covered lives." The determination of covered lives, their value and the payment amount is highly complex and is set forth in detailed statutory language.

Similar to the uncompensated care funding approach, a payer may alternatively choose to pay a GME surcharge on an encounter basis, i.e., as a surcharge on the hospital bill. Here again, the encounter surcharge will equal an amount equivalent to the "covered lives" levy plus an additional 24 percent. Each teaching hospital will receive a monthly payment from the applicable regional pool based on its adjusted share of a region's total adjusted GME spending.

Health Care Initiatives

A third pool of funds, the health care initiatives pool, is established to support programs designed to expand access to health insurance, monitor and improve quality, provide for restructuring of the health care system and retraining for the health care workforce. Funding for this pool is derived from the same mechanism as is used for the uncompensated care pool.

Among the dozen-plus programs to be funded from the initiatives pool are:

* The Child Health Insurance Program (CHIP), also known as Child Health Plus, which provides health insurance to low-income children. CHIP was created in 1991 with coverage limited to primary and preventive care of children under the age of 13. In 1994, the program became available to children under the age of 15. Effective Jan. 1, 1997, it becomes available to children under the age of 19. Also effective Jan. 1, 1997, CHIP coverage is extended to all inpatient health care services except mental health, substance abuse and alcohol treatment services. The total amount of funding for CHIP is $ 120.6 million in 1997, rising to $ 181 million in 1999. As before, CHIP is available only to children who do not have equivalent coverage under another plan.

* Funding of $ 6 million is provided to establish the New York State Small Business Health Insurance Partnership Program, which is designed to assist eligible employers to purchase small group health insurance policies for their full-time employees and dependents. To participate in the program, eligible employers must submit applications to the Commissioner of Health for approval.

* Funding of $ 5 million is available for the voucher insurance program, a demonstration program to assist individuals and families residing in specified urban and rural areas to buy health care coverage through insurers, HMOs and integrated delivery systems.

* An annual minimum of $ 20 million will be available for the restructuring of health care facilities. The restructuring funds are allocated to assist facilities in the formation or strengthening of networks, affiliations or

other business combinations designed to provide long-term financial stability; to offset the costs of engaging management, legal or accounting consultants; and for loans for the payment of debt service or bonds, notes or other obligations issued or incurred by the State Dormitory Authority or the New York State Medical Care Facilities Finance Agency.

* Grant funding – $ 50 million in 1997 – for training and retraining of displaced health care workers will be made available on a regional basis in areas where significant job losses have occurred or are anticipated as a result of changes in the health care field. Among the organizations eligible to seek these funds are hospitals, long-term care facilities, labor unions, labor-management organizations, managed care organization and trade associations.

* Grant funding of $ 30 million is available to assist health care providers in the transition to competitive system. Funds may be used for developing health care provider networks, promoting the reconfiguration and restructuring of health care delivery, and developing information systems to facilitate integration.

* An annual total of $ 8 million will be provided to fund quality improvement and quality measurement grants, to be awarded based on the recommendations of a newly created Task Force on Health Care Quality Improvement and Information Systems.

* Grant programs also are established for many other public and primary health care programs, including emergency medical services programs, development of special HIV services for infants and pregnant women, and expansion of primary care through the physician

loan repayment program, the primary care practitioner scholarship program, and minority participation in medical education.

Using funds from the initiatives pool, the Reform Act also provides $ 17 million in total assistance for rural health care providers. These funds, to be available as direct funding and grants, are designed to support facility improvements, the purchase of major medical and non-medical equipment, the development of management information systems, the transition of rural hospitals into managed care, and the expansion of primary and preventive care services in rural areas.

Creation of IDS

By the addition of new §4408-a to the Public Health Law, the Health Care Reform Act creates a new category of managed care licensure known as "integrated delivery systems" (IDS), often commonly referred to as provider-sponsored networks. An IDS would be a legal entity composed of or controlled by one or more affiliated providers which would be authorized to deliver comprehensive health care services on a capitated [sic] basis to certain defined patient groups.

Providers eligible to affiliate the operate as an IDS include hospitals, nursing homes, home health care agencies, substance abuse providers, residential treatment facilities for the mentally retarded and mentally ill, and physicians. One significant limitation is a provision that prohibits publicly traded corporations from operating an IDS, mirroring New York's similar unique prohibition on

publicly traded companies' ownership of hospitals, nursing homes and clinics.

Integrated delivery systems will be regulated primarily by the Department of Health, with significant input from the Insurance Department on issues relating to fiscal solvency and the development of premium rates. A qualified IDS must deliver comprehensive HMO-like services with at least 75 percent of these services delivered through its network of affiliated providers, all of which must share "substantial financial risk" in the venture's operation.

In recognition of this structure, the Superintendent of Insurance is authorized to develop unique solvency standards for integrated delivery systems which would not exceed HMO standards and which "recognize and consider the specific delivery components, operational capacity and financial capability" of an IDS. This provision allows the Superintendent to promulgate solvency standards which more appropriately recognize the risks inherent in the delivery of services as contrasted with the higher risks involved when a insurance entity must purchase services.

An approved IDS would be eligible to deliver services to the following groups on a capitated basis:

* Medicare patients, if and when the federal government authorizes IDS risk assumption for this population;

* Medicaid patients and commercial enrollees; or

* Medicare (subject to federal approval noted above), Medicaid patients and commercial enrollees, including self-insured plans.

The IDS authorization expires on April 1, 2002, and no new approvals to operate will be issued after that date and no new enrollee approvals would be authorized.

Conclusion

The Health Care Reform act is not a simple deregulation of the old hospital pricing system. Designed to serve a multitude of purposes, the Act includes many new approaches to impose financing mandates on payers while simultaneously moving the multi-billion dollar hospital system into the open marketplace.

It remains to be seen whether the funding schemes will prove adequate and withstand potential challenges. The surcharge options offered to payers, including self-insured plans and third-party administrators, as well as insurers, are accompanied with various reporting and other administrative requirements, raising the potential for yet another round of ERISA preemption litigation.

Undoubtedly, the ACT's complexity will require a series of ameliorative statutory amendments. At present, though, it stands as a monumental effort to promote the evolution of the state's hospital system into the next century.

LANGUAGE: ENGLISH

LOAD-DATE: September 03, 1996

EXHIBIT B

Table 5.1
Private Pension Plans and Participants

Summary of Private-Sector Qualified Defined Benefit and Defined Contribution Plans and Participants, 1975–1990

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
	(thousands)															
Total Plans	311	360	403	443	471	489	546	594	603	601	632	718	733	730	731	712
Defined benefit[a]	103	114	122	128	139	148	167	175	175	165	170	173	163	146	132	113
Defined contribution[a]	208	246	281	315	331	341	378	419	428	436	462	545	570	584	599	599
Defined contribution as percentage of total	67%	68%	70%	71%	70%	70%	69%	71%	71%	73%	73%	76%	78%	80%	82%	84%
	(millions)															
Total Participants	45	48	50	52	55	58	61	63	69	74	75	77	78	78	76	77
Defined benefit[b]	33	34	35	36	37	38	39	39	40	41	40	40	40	41	40	39
Defined contribution[b]	12	13	15	16	18	20	22	25	29	33	35	37	38	37	36	38
Defined contribution as percentage of total	27%	28%	30%	31%	33%	34%	36%	39%	42%	45%	47%	48%	49%	48%	48%	50%
Active Participants	31	32	33	34	35	36	37	37	39	40	40	41	42	42	43	42
Primary plan is defined benefit	27	27	28	29	29	30	30	29	30	30	29	29	28	28	27	26
Primary plan is defined contribution	4	5	5	5	6	6	7	8	9	10	12	13	13	14	15	16

Source: Employee Benefit Research Institute tabulations based on John A. Turner and Daniel J. Beller, eds., *Trends in Pensions*, Second edition (Washington, DC: U.S. Department of Labor, 1992); U.S. Department of Labor, Pension and Welfare Benefits Administration, *Private Pension Plan Bulletin* (Winter 1993); and U.S. Department of Labor, Pension and Welfare Benefits Administration, *Private Pension Plan Bulletin* (Summer 1993).

[a]Excludes single participant plans.

[b]Active, separated vested, survivors, and retired. Not adjusted for double counting of individuals participating in more than one plan.

EXHIBIT C

Table 8.1
Health Insurance Coverage of the Elderly and Nonelderly

Nonelderly and Elderly Populations with Selected Sources of Health Insurance Coverage, 1989–1993

Source of Coverage	Total Population					
	1989	1990	1991	1992	1992 (revised)	1993
	(weight based on 1990 census)[a]				(weight based on 1980 census)[a]	
	(millions)					
Total Population	243.3	246.0	248.7	251.7	254.2	256.9
Total with Private Health Insurance	180.4	178.9	178.4	177.5	178.1	178.0
Employer coverage	150.2	148.7	150.0	148.0	148.6	147.4
Other private coverage	30.3	30.3	28.6	29.6	29.7	31.2
Total with Public Health Insurance	54.5	58.1	61.2	63.2	63.6	65.8
Medicare	31.5	32.3	32.9	33.7	33.2	33.0
Medicaid	21.1	24.2	26.8	28.5	29.4	31.6
CHAMPUS/CHAMPVA[b]	7.0	7.0	7.1	6.9	6.9	6.8
No Health Insurance	34.7	36.0	36.6	38.9	40.1	41.2
	(percentage)					
Total Population	100.0%	100.0%	100.0%	100.0%	100%	100.0%
Total with Private Health Insurance	74.2	72.7	71.7	70.5	70.1	69.3
Employer coverage	61.8	60.4	60.3	58.8	58.5	57.4
Other private coverage	12.4	12.3	11.5	11.8	11.7	12.1
Total with Public Health Insurance	22.4	23.6	24.6	25.1	25.0	25.6
Medicare	12.9	13.1	13.2	13.4	13.1	12.9
Medicaid	8.7	9.8	10.8	11.3	11.6	12.3
CHAMPUS/CHAMPVA[b]	2.9	2.8	2.9	2.7	2.7	2.6
No Health Insurance	14.3	14.6	14.7	15.4	15.8	16.1

(continued)

Table 8.1 (continued)
Health Insurance Coverage of the Elderly and Nonelderly

Source of Coverage	Nonelderly					
	1989	1990	1991	1992	1992 (revised)	1993
	(weight based on 1990 census)[a]				(weight based on 1980 census)[a]	
	(millions)					
Total Population	213.7	215.9	218.1	220.8	223.8	226.2
Total with Private Health Insurance	160.4	158.3	157.7	156.6	157.5	157.7
Employer coverage	140.8	138.7	139.8	138.0	138.7	137.4
Other private coverage	19.7	19.7	18.0	18.8	19.0	20.8
Total with Public Health Insurance	26.2	29.2	31.7	33.4	34.3	36.3
Medicare	3.2	3.5	3.5	4.0	3.9	3.7
Medicaid	18.5	21.6	23.9	25.6	26.5	28.9
CHAMPUS/CHAMPVA[b]	5.9	5.9	5.9	5.7	5.8	5.6
No Health Insurance	34.4	35.7	36.3	38.5	39.8	40.9
	(percentage)					
Total Population	100.0%	100.0%	100.0%	100.0%	100%	100.0%
Total with Private Health Insurance	75.0	73.3	72.3	70.9	70.4	69.7
Employer coverage	65.9	64.2	64.1	62.5	62.0	60.8
Other private coverage	9.2	9.1	8.2	8.5	8.5	9.2
Total with Public Health Insurance	12.2	13.5	14.5	15.1	15.3	16.1
Medicare	1.5	1.6	1.6	1.8	1.8	1.6
Medicaid	8.7	10.0	11.0	11.6	11.8	12.8
CHAMPUS/CHAMPVA[b]	2.8	2.7	2.7	2.6	2.6	2.5
No Health Insurance	16.1	16.6	16.6	17.4	17.8	18.1

(continued)

Table 8.1 (continued)
Health Insurance Coverage of the Elderly and Nonelderly

Source of Coverage	Elderly					
	1989	1990	1991	1992	1992 (revised)	1993
	(weight based on 1990 census)[a]				(weight based on 1980 census)[a]	
	(millions)					
Total Population	29.6	30.1	30.6	30.9	30.4	30.7
Total with Private Health Insurance	20.0	20.6	20.7	20.9	20.6	20.3
Employer coverage	9.4	10.0	10.1	10.1	9.9	9.9
Other private coverage	10.6	10.6	10.6	10.8	10.7	10.4
Total with Public Health Insurance	28.3	28.9	29.5	29.8	29.4	29.4
Medicare	28.2	28.8	29.4	29.7	29.3	29.3
Medicaid	2.6	2.6	2.9	2.9	2.9	2.7
CHAMPUS/CHAMPVA[b]	1.1	1.1	1.2	1.2	1.2	1.2
No Health Insurance	0.3	0.3	0.3	0.4	0.3	0.4
	(percentage)					
Total Population	100.0%	100.0%	100.0%	100.0%	100%	100.0%
Total with Private Health Insurance	67.7	68.4	67.7	67.7	67.8	66.0
Employer coverage	32.0	33.2	33.1	32.6	32.7	32.3
Other private coverage	35.7	35.2	34.7	35.0	35.2	33.7
Total with Public Health Insurance	95.8	96.0	96.3	96.6	96.6	95.8
Medicare	95.6	95.7	96.0	96.2	96.3	95.5
Medicaid	8.7	8.6	9.5	9.4	9.4	8.8
CHAMPUS/CHAMPVA[b]	3.7	3.7	3.8	3.9	3.8	3.8
No Health Insurance	1.0	1.0	0.9	1.2	1.1	1.2

Source: Sarah C. Snider and Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1994 Current Population Survey," *EBRI Issue Brief* no. 158 (Employee Benefit Research Institute, February 1995).

Note: Details may not add to totals because individuals may receive coverage from more than one source. See Appendix B for a technical explanation of this source.

[a]The 1989 data through the first set of 1992 data are based on 1980 census-based population controls. The second set of 1992 data (as revised) and 1993 data are based on 1990 census-based population controls. While the change in weighting has little effect on the percentage distributions, it does effect levels. Thus, by reweighting the 1992 data, these numbers may more accurately be compared with the more recent 1993 data.

[b]Includes only the retired military and members of their families provided coverage through the Civilian Health and Medical Program for the Uniformed Services and the Civilian Health and Medical Program of the Veterans Administration. Excludes active duty military personnel and members of their families.

EXHIBIT D

Table 6.9
Pension Assets

Financial Assets[a] of Private and Public Pension Plans, Selected Years 1950–1993

	1950	1960	1970	1980	1985	1986	1987	1988	1989	1990	1991	1992	1993
							($ billions)						
All Funds and Reserves	$25	$91	$241	$902	$1,982	$2,323	$2,515	$2,743	$3,230	$3,252	$3,845	$4,135	b
Private Funds	13	57	153	628	1,435	1,692	1,818	1,938	2,279	2,265	2,734	2,876	b
Private Trusteed Funds	7	38	112	470	1,088	1,282	1,359	1,422	1,706	1,629	2,056	2,181	$2,336
Equity	1	17	67	224	464	551	539	610	735	658	889	946	1,097
Bonds	5	18	33	128	346	403	433	455	539	559	640	677	700
Cash items	c	1	2	49	123	153	178	207	238	224	273	281	255
Other assets	1	3	11	69	154	176	209	150	194	189	254	277	302
Private Insured Reserves	6	19	41	158	347	410	459	516	573	636	678	695	b
Separate accounts	d	d	5	31	74	88	88	98	115	122	159	186	b
General accounts	6	19	36	127	273	322	371	418	458	514	519	509	b
Public Funds	12	34	88	274	547	631	697	805	951	987	1,111	1,259	1,396
State and local government	5	20	60	197	398	462	508	597	722	737	834	955	1,065
Federal Civilian	4	10	23	74	145	163	182	200	220	241	266	292	319
Railroad	3	4	5	3	4	6	7	8	9	9	11	12	12

Source: Employee Benefit Research Institute (EBRI) tabulations of U.S. Federal Reserve Board, *Flow of Funds Accounts Flows and Outstandings, Fourth Quarter 1993* (Washington, DC: Board of Governors of the Federal Reserve System, 1993); and EBRI tabulations of American Council of Life Insurance, *1993 Life Insurance Fact Book Update* (Washington, DC: American Council of Life Insurance, 1993).

[a]Includes only those assets included within Federal Reserve Board's Flow of Funds accounts. The Flow of Funds accounts are restricted to only certain "financial assets" and therefore exclude such assets as real estate, physical property, and receivables. All nonequity holdings are estimated at book value. Short-term government bonds and all bonds with long-term original date-to-maturity are classified as bonds. Mutual funds are classified as other assets.

[b]Data are not available.

[c]Less than $500 million.

[d]No assets in this category.

EXHIBIT E

Table 2.2
Employer Spending for Benefits

Employer Outlays for Selected Employee Benefits by Function, Selected Years 1960–1993

	1960	1970	1980	1990	1991	1992	1993
				($ billions)			
Total Compensation	$296.7	$618.3	$1,644.4	$3,292.3	$3,399.4	$3,585.4	$3,774.4
Wages and Salaries[a]	272.8	551.5	1,376.6	2,745.0	2,816.0	2,954.8	3,100.8
All Benefits	23.7	66.2	265.8	547.3	583.4	630.6	673.6
Retirement Income Benefits	14.2	40.3	151.6	260.6	275.1	294.6	311.1
Social Security Old-Age, Survivors, and Disability Insurance	5.6	16.2	55.6	137.0	142.5	149.4	156.3
Private employer pension and profit sharing	4.9	13.1	55.3	49.5	54.3	62.7	68.2
Public employer retirement plans	3.7	11.0	40.7	74.1	78.3	82.5	86.6
federal civilian employee retirement[b]	0.8	2.2	7.4	16.1	17.9	19.4	20.8
state and local government retirement	1.8	5.1	19.1	33.3	34.0	35.3	36.8
military retirement[c]	0.8	3.2	12.5	22.1	23.8	25.1	26.3
railroad retirement	0.3	0.5	1.7	2.6	2.6	2.7	2.7
Health Benefits	3.4	14.6	73.0	211.7	230.6	254.7	275.6
Medicare Hospital Insurance	0.0	2.3	11.6	33.6	34.7	36.5	38.2
Group health insurance	3.4	12.1	61.0	176.6	194.2	216.5	235.6
Military medical insurance[d]	0.0	0.2	0.4	1.5	1.7	1.7	1.8
Other Employee Benefits	6.1	11.3	41.2	75.0	77.7	81.3	86.9
Unemployment insurance[e]	3.0	3.8	16.4	22.9	22.2	25.6	28.4
Workers' compensation	2.0	4.6	19.3	46.0	49.3	49.8	52.6
Group life insurance	1.1	2.9	5.5	6.1	6.2	5.9	5.9

Source: Employee Benefit Research Institute tabulations based on U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business, July 1994* (Washington, DC: U.S. Government Printing Office, 1994); and *The National Income and Products Accounts of the United States: Statistical Supplement, 1959–1988*, Vol. 2 (Washington, DC: U.S. Government Printing Office, 1992).

[a]Includes paid holidays, vacations, and sick leave taken.

[b]Consists of civil service, foreign service, Public Health Service officers, Tennessee Valley Authority, and several small retirement programs.

[c]Includes the U.S. Coast Guard.

[d]Consists of payments for medical services for dependents of active duty military personnel at nonmilitary facilities.

[e]Consists of state, railroad employee, and federal employee unemployment benefits; special unemployment benefits; and supplemental unemployment benefits.